Desert
Foot and Ankle, P.C.

1520 S. Dobson Road, Suite 307, Mesa, Arizona 85202
480-844-8218 Fax 480-844-9950
www.desertfootandankle.com

PATIENT REGISTRATION

Patient Name_____ Age_____ Birthdate_____
Parent/ Guardian name (if minor)_____
Billing Address_____City_____State_____Zip_____
Permanent Address_____City_____State____ Zip_____
Home Phone_____ Work Phone_____ Cell_____
May we leave a message regarding medical care, billing, or other issues? ( ) Yes ( ) No
Would you like to receive text message appointment reminders? ( ) Yes ( ) No
Email address_____ Race/ Ethnicity (optional)_____
Patient Social Security #_____ Sex: ____Male ____Female
Marital Status: _____Married _____Single _____Other
Primary Care Doctor_____Phone_____
Referred by_____
Full Time Student? Y N Employer name_____
In case of emergency notify_____
Emergency contact phone_____ Relationship to patient_____

Who is responsible for this account?
___Self (skip this section) ___Spouse ___Father ___ Mother ___Other_____
Name_____ Birthdate_____
Social Security Number_____
Home Phone_____ Cell_____Email address_____
Employer_____Work Phone_____
Billing Address_____

INSURANCE INFORMATION

Primary Insurance Company_____
Insurance ID Number_____ Group Number_____
Policy Holder Name_____
Relationship to Patient_____ Birthdate_____

Secondary Insurance Company_____
Insurance ID Number_____ Group Number_____
Policy Holder Name_____
Relationship to Patient_____ Birthdate_____

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Foot and Ankle, P.C.

1520 S. Dobson Road, Suite 307, Mesa, Arizona 85202
16838 E. Palasades Blvd., Suite A105, Fountain Hills, Arizona 85268
480-844-8218 Fax 480-844-9950
www.desertfootandankle.com

Patient's Name _____ Birthdate _____

Height _____ Weignt _____ Shoe Size _____

Chief Complaint (reason for visit) _____

If Injury was it: Auto accident? Y N Work related? Y N Date of Injury _____

Medications: Prescriptions & Non-Prescriptions (include herbal remedies) . ☐ **I do not take any medications**

NAME OF MEDICINE	DOSE	HOW OFTEN TAKEN

Pharmacy Name & Cross Roads _____

Please check "√" if you currently have or if you have had a history of:

ALLERGIES		SURGERIES	YEAR		AUTOIMMUNE HISTORY	
Adhesives		Appendectomy			Lupus	
Anesthetics		Arthroscopy			Sarcoidosis	
Antihistamines		Back			Scleroderma	
Aspirin		Bladder			Other	
Codeine		Breast L R				
Darvon		Colon			**BLOOD DISORDERS**	
Demerol		Ears L R			Anemia	
Iodine/Betadine		Eyes L R			Frequent Bruising	
Latex products		Foot L R			Blood Transfusions	
Mercurial		Gall Bladder			Leukemia	
Merthiolate		Heart			Trouble Clotting Blood	
Novocaine		Hernia			Other	
Nylon/Plastic		Hip L R				
Penicillin		Hysterectomy			**CIRCULATORY HISTORY**	
Seconal		Knee L R			Blood Clots	
Sulfa		Neck			Hodgkin's Disease	
Tetanus		Nose			Legs/Feet Swelling	
Tetracycline		Prostate			Lymphoma	
Other		Shoulder L R			Phlebitis	
		Tonsillectomy			Varicose Veins	
		Other			Vascular Disease	
					Other	
		ANESTHESIA PROBLEMS? Y N				

Past Accidents / Injuries _____

Please check "√" if you currently have or if you have had a history of:

CARDIAC HISTORY		GENITOURINARY		RESPIRATORY	
Angioplasty		Bladder Infections		Asthma	
Atrail Fibrillation		Blood in Urine		Bronchitis	
Chest Pain (Angina)		Dialysis		COPD	
Congestive Heart Failure		Kidney Problems / Stones		Chronic Cough	
Cholesterol Issues		Painful Urination		Emphysema	
Coronary Artery Disease		Prostate Problems		Hay Fever	
Heart Attack		Renal Failure		Pneumonia	
High Blood Pressure		Other		Shortness of Breath	
Irregular Heart Beat				Sleep Apnea	
Mitral Valve / Valve Problems		**INFECTIOUS DISEASE**		Tuberculosis	
Murmur		C-difficile		Valley Fever	
Pacemaker / Defibrillator		Fever Currently		Wheezing	
Cardiac Stents		HIV / AIDS		Other	
Other		Mononucleosis			
ENDOCRINE HISTORY		MRSA		**REPRODUCTIVE**	
Diabetes		Tuberculosis		Are You Pregnant?	
Hypoglycemia		Other		Endometriosis	
Thyroid Problems				Fibroids	
Unexplained Weight Loss		**MUSCULOSKELETAL**		Breast Feeding Currently	
Other		Arthritis Osteo / Rheumatoid		Other	
HEAD		Chronic Back Problems			
Blindness		Difficulty Opening Mouth		**SKIN DISORDERS**	
Cataracts L R		Fibromylagia		Eczema	
Difficulty Swallowing		Gout		Psoriasis	
Deafness L R		Joint Pain		Rash Currently	
Glaucoma L R		Metal, Pins, Plates, Screws		Skin Cancer	
Hard of Hearing L R		Muscle Pain, Weakness		Skin Sores or Open Wound	
Head / Neck Injury		Polio		Trouble Healing Wounds	
Macular Degeneration		Other		Other	
Nose Bleeds					
Other		**NEUROLOGICAL**		**SUBSTANCE USE**	
GASTROINTESTINAL		Alzheimer's / Dementia		Alcohol Present / Past	
Cirrhosis / Liver Disease		Aneurysm		How Much?	
Colitis / Irr. Bowel Disease		Depression		Smoking Present / Past	
Colon Problems / Polyps		Head Injury		How Much?	
Crohn's Disease		Headaches / Migraines		Living with a Smoker?	
Diverticulosis		Memory Loss		Other Substances Used:	
Heartburn (Frequent)		Multiple Sclerosis			
Hemorrhoids		Numbness & Tingling			
Hepatitis		Parkinson's Disease			
Hiatal Hernia		Seizures / Epilepsy		**CANCER OF ANY KIND** (List)	
Pancreatitis		Stroke/TIA or mini-stroke			
Reflux Disease / GERD		Tremors			
Stomach Problems / Ulcers		Other			
Other					

Patient's Name _____ Date _____

VASCULAR DISEASE EVALUATION

(PAD & PVD)

Patient Name: _____ **DOB:** _____

PERSONAL HEALTH HISTORY

		SCORE:
PATIENT:	Have Slow/Non-Healing Wounds or Ulcers on foot or lower leg?	10
	Have Diabetes?	7
	Over 65 years of age?	6
	Ever had Lower Extremity Revascularization?	5
	History of Smoking?	5
	Over 50 years of age?	4
	History of Hypertension?	4
	Resting Leg Pain or Foot Pain?	4
	One foot ever Colder than the other?	4
	Have Neuropathy?	4
	Have High Cholesterol?	3
	Ever had a Heart Attack or Stent?	3
	Total Added Score:	

****If Patient Scores Above 10, Send for Vascular Evaluation****

(Patient may be at risk for PAD/PVD and needs screening immediately)

SOUTH PHX / CHANDLER

Fax: (623) 321-6430

Desert Foot & Ankle PC

Family Medical History Questionnaire

Date:
Patient Name
Date of Birth:

Has your mother (M), father (F), sister (S), or brother (B) had:

Asthma/Wheezing	Yes ____	No ____	Who? ____
TB/Lung Disease	Yes ____	No ____	Who? ____
Cystic Fibrosis	Yes ____	No ____	Who? ____
HIV/AIDS	Yes ____	No ____	Who? ____
Heart Disease (Cardiovascular Disease)	Yes ____	No ____	Who? ____
Sudden Cardiac Death	Yes ____	No ____	Who? ____
High Blood Pressure (Hypertension)	Yes ____	No ____	Who? ____
Stroke	Yes ____	No ____	Who? ____
High Cholesterol	Yes ____	No ____	Who? ____
Blood Disorders	Yes ____	No ____	Who? ____
Sickle Cell	Yes ____	No ____	Who? ____
Anemia	Yes ____	No ____	Who? ____
Thalassemia	Yes ____	No ____	Who? ____
Clotting Disorders	Yes ____	No ____	Who? ____
Diabetes Type I	Yes ____	No ____	Who? ____
Diabetes Type 2	Yes ____	No ____	Who? ____
Seizures	Yes ____	No ____	Who? ____
Cancer	Yes ____	No ____	Who? ____
Breast	Yes ____	No ____	Who? ____
Cervical	Yes ____	No ____	Who? ____
Colorectal	Yes ____	No ____	Who? ____
Other_____	Yes ____	No ____	Who? ____
Birth Defects	Yes ____	No ____	Who? ____
Hearing Loss	Yes ____	No ____	Who? ____
Speech Problems	Yes ____	No ____	Who? ____
Kidney Disease	Yes ____	No ____	Who? ____
Alcohol/ Drug Abuse	Yes ____	No ____	Who? ____
Hepatitis/ Liver Disease	Yes ____	No ____	Who? ____
Thyroid Disease	Yes ____	No ____	Who? ____

Has any family member ever had an unexplained, unexpected death before age 50?

Yes ____ No ____ Who? ____

If yes, please describe: _____

_____

Financial Policy

You are financially responsible for the medical services you receive at Desert Foot and Ankle, P.C. (hereafter referred to as the "Practice"). Please carefully review, initial each section and sign the agreement to indicate your acceptance of its terms.

APPOINTMENTS

1. **Copayments and Deductibles.** Copayments and deductibles for clinic visits are due at the time of service, in accordance with your insurance carrier's plan. If you are unable to make your copayment at the time of service, the Practice reserves the right to reschedule your appointment until such time that you are able to make your copayment.

2. **Procedure Prepayment.** The Practice may collect your payment for a procedure at the time the procedure is scheduled. Your prepayment is based on an estimate of your expected financial responsibility. We reserve the right to reschedule your procedure until prepayment arrangements have been made. You are responsible for any unpaid balance after your insurance carrier has processed your claim. In the event of overpayment, you may request a refund.

3. **Self-Pay.** If you do not have health insurance, or if your health insurance will not pay for services rendered by the Practice or if you notify us not to contact or bill your insurance company, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available at our front desk). Payment is due in full at the time of service.

4. **Missed Appointments and Late Arrivals.** You will be charged a fee for each incident according to the Public Fee Schedule. These charges are your personal responsibility and will not be billed to any insurance carrier. **Initial:** _____

INSURANCE PAYMENTS

5. **Financial Responsibility.** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurance carrier will be your responsibility, except as limited by the Practice's specific network agreement with your insurance carrier, if such an agreement is in place.

6. **Coverage Changes and Timely Submission.** It is your responsibility to timely inform us of any change to your billing or insurance information. Your insurance carrier places a time limit within which the Practice can submit a claim on your behalf. If the Practice is unable to process your claim within this period due to your providing incorrect insurance information or not responding to insurance carrier inquiries, you will be responsible for all charges.

7. **Insurance Plan Participation.** The Practice has specific network agreements with many insurance carriers, but not all insurance carriers. It is your responsibility to contact your insurance carrier to verify that your assigned provider participates in your plan. Your insurance carrier's plan may have out-of-network charges that have higher deductibles and copayments, which you will be responsible for.

8. **Referrals.** Referral and prior authorization requirements vary among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by the Practice, it is your responsibility to obtain this referral prior to your appointment. It is your responsibility to renew your referral before it expires. You are responsible for all charges if we do not have a valid referral, and payment is due at the time of service.
As a matter of course, the practice will inform your referring physician of your patient care plan and progress either by using any secure electronic transmission machine or by an employee of the Practice.

9. **Prior Authorization and Non-Covered Services.** The Practice may provide services that your insurance carrier's plan excludes or require prior authorization. The Practice, as a courtesy to our patients, will make a good-faith effort to determine if services we provide are covered by your insurance carrier's plan, and, if so, determine if prior authorization for treatment is required. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf. Ultimately, it is your responsibility to ensure that services provided to you are covered benefits and authorized by your insurance carrier.

10. **Out-of-Network Payments and Direct Insurer Payments.** You are personally responsible for all charges. If we are not part of your insurance carrier's network (out-of-network) or your insurance carrier pays you directly, you are obligated to forward the payment or payment proceeds to the Practice immediately.
Initial: _____

11. **Reassignment of Balances.** If your insurance carrier does not pay for services within a reasonable time,

we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. **Balances are due within 30 days of receiving an initial statement.**

12. **Collection of Unpaid Accounts.** If this account is not paid in full within 30 days of receiving a statement, I agree to pay a monthly re-billing fee of $3.00 per month until the account is paid in full. In the event the account is turned over to an attorney or collection agency, I agree to pay collection charges and/or attorney fees in the amount of 33% of the balance due. Interest of 18% per year will be accrued on the principal balance. I further agree that the jurisdiction for any action filed for the purpose of collection of any sums due on this account shall be the place where the contract was made, specifically Maricopa County, Arizona. A photocopy or facsimile of this agreement shall be considered as valid as the original. **The Practice reserves the right to refuse treatment to patients with outstanding balances over 120 days old.** You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you at any telephone number associated with your account, including cellular numbers, which could result in charges to you. We may also contact you by text message or e-mail, using any e-mail address you provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device.

13. **Returned Checks.** You will be charged for returned checks according to the Public Fee Schedule.

14. **Refunds.** Refunds for overpayment are processed only after full insurance reimbursement of all medical services has been received. Please submit a written refund request and allow 6 weeks for your request to be processed. Send requests to: Desert Foot and Ankle, P.C. 1520 South Dobson Road, Suite 307 Mesa, Arizona 85202.

15. **Statements.** Charges shown by statement are agreed to be correct and reasonable unless protested in writing within 30 days of the receipt. **Initial:** _____

ADDITIONAL FEES

16. **Medication Refill Requests.** All medication refill requests are to be approved by your provider. A fee will be charged according to the Public Fee Schedule for any of the following requests: lost prescriptions; urgent refill/office visit requests (same or next business day); and refills processed after a missed appointment.

17. **Medical Records Requests.** The Privacy Rule allows you to receive a copy of your personal medical records, billing records and allows the Practice to require individuals to complete and sign an Release of Medical Records Form. However, if you are unable to come into one of the Practice's clinics, the Practice will make every accommodation to fulfill your request. A fee will be charged for medical records requests according to the Public Fee Schedule. There is no charge to transfer a copy of your medical records to a new Provider

18. **Other Forms.** The Practice will respond (at the provider's discretion) to requests for the completion of certain medical forms (FMLA, Short Term Disability & Temporary Disability Parking Permit) assuming the patient is in good standing and has been active with the Practice for six (6) months consecutively. Other forms not listed may be considered for completion by the Practice. In these cases, the fee will be determined by the Office Manager. All requests require an office visit. **Initial:** _____

19. **Acknowledgment of Notice of Privacy Practice.** By initialing this section, I acknowledge that I have received and reviewed a copy of the Practice's Notice of Privacy Practice. **Initial:** _____

20. **Public Fee Schedule.** By initialing this section, I acknowledge that I have received a copy of the Practice's Public Fee Schedule. **Initial:** _____

Practice Code of Conduct

We are pleased to serve you and glad that you chose DFA as your provider. We will always strive to provide exceptional care for you. Please remember to update the Practice of any address and/or telephone number changes, as it is your responsibility.

Reasons that DFA may ask you to seek health care services elsewhere might include:

- Rude or violent behavior to staff via in-person or telephone - this also applies to your family members and/or friends
- Repeated no shows, cancellations, or continual late arrivals for office visits or procedures
- Refusal to adhere to the plan of care as outlined by your provider or to follow health insurance or government guidelines
- Unwarranted requests for disability paperwork **Initial:** _____

Agreement and Assignment of Benefits

I have read and understand the Financial Policy of Desert Foot and Ankle, P.C., and I agree to abide by its terms. I hereby assign all medical, surgical benefits rendered to myself and/or dependents to DFA and authorize my insurance carrier(s) to issue payment directly to DFA. I understand that I am financially responsible for all services I receive from the Practice. This financial policy is binding upon me and my estate, executors and/or administrators, if applicable.

Printed Name: _____

Signed: _____ Date: _____

Reference Number 10.01