Ankle & Foot
Surgical Associates

PATIENT DEMOGRAPHICS

First Name _____ **M.I.** _____ **Last Name** _____

Gender □ F □ M **Birth Date** _____/_____/_____ **SSN#**_____

Street Address _____ **Apt. #** _____ **City** _____ **State** _____ **Zip code**_____

Home Phone (___ **)** _____ **Work Phone (** ___ **)** _____ **Cell Phone (** ___ **)** _____

E- Mail Address _____

Marital Status □ **Married** □ **Divorced** □ **Separated** □ **Single** □ **Widowed** **Primary Language** _____

Race: (Choose all that apply)
- □ American Indian or Alaska Native
- □ Asian
- □ Black or African American
- □ Native Hawaiian or other Pacific Islander
- □ White
- □ Latino

Ethnicity: (Choose one that applies)
- □ Hispanic
- □ Not Hispanic

Primary Care Physician _____ **Phone#** _____

Are you diabetic? Yes / No **If yes, name of physician managing diabetes**_____ **Date last seen** _____

Pharmacy_____ **Phone #** _____ **Address**_____

Emergency Contact _____ **Relationship to Patient** _____
Cell Phone Number (___ **)** _____ **Alternate Phone Number (** ___ **)** _____

Employed PT / FT / Retired / None **Employer** _____

How did you hear about our practice? □ **Health Fair** □ **Doctor Referral (Name of Doctor:)**_____
□ **Internet** □ **Ad** □ **Friend/Family Member** □ **Other:** _____

Insurance Information

A. Primary Insurance Company:_____
Insurance ID Number:_____
Group Number:_____
Primary Subscriber Name:_____
Primary Subscriber Birth Date:_____
Relationship to Patient: _____

B. Secondary Insurance Company: _____
Insurance ID Number:_____
Group Number: _____
Primary Subscriber Name:_____
Primary Subscriber Birth Date:_____
Relationship to Patient:_____

Financially Responsible Person First Name Last Name

First Name _____ **M.I.** ___ **Last Name** _____ **Gender** □ F □ M **Birth Date** _____/_____ / _____
Street Address _____ **Apt. #** _____ **City** _____ **State** _____ **Zip code**_____
Home Phone (___ **)** _____ **Work Phone (** ___ **)** _____ **Cell Phone (** ___ **)** _____

Patient's Authorization and Assignment of Benefits:

I hereby authorize the processing of the medical insurance either by electronic or manual method by Ankle & Foot Surgical Associates. My signature authorizes payment for all major medical and/or durable medical equipment supplies and/or surgical benefits to which I am entitled from the listed insurer(s) above and/or by providing my insurance cards to the office to pay for services rendered to AFS. I certify that the information, I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I grant permission to contact me via email. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I recognize my financial obligation of any balance, co- insurance, deductible, and non- covered services that may be required.

Signature of Responsible Party _____ **Date** _____

Relationship (if not patient) _____

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MEDICAL HISTORY

First Name _____ **M.I.** _____ **Last Name** _____**DOB** _____

Age _____ **Height** _____ **Weight** _____ **Shoe Size** _____ **Reason for visit**_____

How long has this been a problem? _____ **When does it occur (circle)?** Morning Afternoon Evening Off &On All Day

TREATMENTS: Please list previous treatments (either prescribed or home remedies): _____
_____

Is this visit related to an accident/injury? Y N - if yes, date of injury_____

MEDICATIONS: Please list (or attach a list) of your current medications and their dosages:

_____ _____ _____
_____ _____ _____
_____ _____ _____

ALLERGIES: Do you have a history of allergies/skin reaction/sickness following the administration of any of the following:

	Y N ** If yes, list REACTION		Y N ** If yes, list REACTION
Adhesive tape	__ __ _____	**Foods**	__ __ _____
Anesthesia	__ __ _____	**Iodine**	__ __ _____
Aspirin	__ __ _____	**Latex**	__ __ _____
Caffeine	__ __ _____	**Local Anesthetics**	__ __ _____
Codeine	__ __ _____	**Penicillin**	__ __ _____
Cortisone	__ __ _____	**Sulfa Drugs**	__ __ _____
Demerol	__ __ _____	**Other, please list:**	_____

MEDICAL HISTORY: please indicate which applies

____Alcohol/Drug addiction/dependency
____Alzheimer's/Dementia
____Anemia – type_____
____Arrhythmias – type _____
____Arthritis - type_____
____Asthma circle (adult or childhood)
____Bleeding/Clotting Problems – type_____
____Cancer - type_____
____Depression/Anxiety disorder/Bipolar depression/other
____Diabetes (TYPE 1 / TYPE 2)
____Emphysema/COPD
____Glaucoma
____Gout
____GERD (Reflux)/GI ulcers (circle)
____Headaches / Migraines
____Hearing Problems
____Heart Disease
____Hepatitis A B C/Liver Disease _____
____High Blood Pressure
____High Cholesterol
____HIV/ Aids/ARC
____Kidney/ Renal Disease
____Lung Disease/Pulmonary Embolus
____Lyme's Disease
____Nervous Condition (type?)_____
____Osteoporosis/Osteopenia (circle)
____Phlebitis (blood clots in legs)
____Pregnancy: are you currently pregnant? Due date: _____
____Poor Circulation/PVD
____Rheumatic Fever/Scarlet Fever
____Schizophrenia
____Seizures/Epilepsy
____STD's (sexually transmitted ds.)
____Sickle Cell Trait/Disease
____Stroke/TIA's
____Thyroid Problems (Hyper / Hypo)
____Tuberculosis
____Other, Please Specify_____
____Other, Please Specify_____
____NONE of the above

PLEASE FILL OUT COMPLETELY

SMOKING
Do you or have you ever smoked? Y N
If yes, how many years? _____ How long ago did you quit? _____

ALCOHOL USE
Do you or did you ever drink alcoholic beverages? Y N
How many drinks will you consume in a day? ____ Week? _____
How long ago did you quit? _____

RECREATIONAL DRUG USE
Do you or have you ever used illicit/recreational drugs? YES NO
If yes, which ones? _____
How long ago did you quit? _____

HOSPITALIZATION: Y N If yes, please list: _____
SURGICAL HISTORY: Y N If yes, please list the surgeries you have had in the past 7 years:
_____

Consent for Treatment: I certify that the information above is true and correct to the best of my knowledge. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance. By signing below, I hereby authorize Ankle & Foot Surgical Associates to obtain medication history from community pharmacies and/or pharmacy benefit managers for the purpose of ongoing treatment. I give permission to Ankle & Foot Surgical Associates to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet, ankles, and lower legs.

Signature of Responsible Party_____ **Date**_____

Relationship (if not patient) _____

Ankle & Foot Surgical Associates

FINANCIAL POLICY

(Please Read, Initial Each Financial Policy Line Sign At the Bottom of the Form)

Welcome to Ankle & Foot Surgical Associates and thank you for selecting our practice. We are committed to providing you with the best possible care. If you have medical insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our policy.

_____(initial) Your insurance is a contract between you and the insurance company. It is your responsibility to understand the benefits of your plan for any and all services. We cannot guarantee payment of your claims that we file. We file as a courtesy to you and your insurance company will not give us a guarantee of coverage. If your insurance company pays only a portion of your claim or rejects your claim, you and/or the policyholder should make an inquiry to your insurance company. Payment delays or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. All checks returned are subject to a $35.00 fee.

_____(initial) We participate in a number of health insurance plans. All patients are required to pay their co- pay, co- insurance, deductibles, and any patient balances owed of all visits, at the time of their visit. In addition, HMO patients must present a valid referral/authorization from their primary physicians at check in. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered" or you do not have an authorization, you will be responsible for the entire charge for all services rendered. We will attempt to verify benefits for some specialized services; however you remain responsible for charges to any service rendered. Patients are encouraged to contact their insurance company for clarification of benefits prior to services rendered. In the event you do not satisfy your financial responsibilities, the practice may use a collection agency, may provide protected health information to that agency. If such agency is used, you will be responsible for a 35% balance- based collection fee and any additional costs related to satisfying that debt, including, but not limited to, court costs, and/or reasonable attorney fees that may be incurred in the collection of an outstanding balance affiliated with satisfying your financial responsibility.

_____(initial) MEDICARE PATIENTS – Please understand that we participate with Medicare. However, you are responsible for your coinsurance, deductible, and any non- covered services. If Medicare has provided reimbursement for services rendered, and if your supplemental insurance does not cover services, then you become responsible for the balance.

_____(initial) In order for us to service your account and/or to collect any amounts you may owe, Ankle & Foot Surgical Associates, and our agents may contact you by telephone at any phone number associated with your account, including wireless telephone numbers. We may also contact you by sending text messages or emails, using any email address you provide us to use. Methods of contact may include using pre-recorded or artificial voice messages and/or use of an automatic dialing device, as applicable.

_____(initial) Missed appointments: You will be billed a $35.00 charge for missed appointments not cancelled with at least 24 hours' notice. FMLA / Disability forms are subject to a fee of $35.00 which needs to be paid prior to completion of the forms.

_____(initial) If you believe your insurance company has made an error or not adequately addressed your claims you may contact the insurance company and/or file a grievance or appeal with your state.

I, _____, have read and I understand the above financial policies. These policies are subject
(Name of patient)
to change without prior written confirmation.

Signature of Responsible Party_____ **Date**_____

Relationship (if not patient) _____

Ankle & Foot Surgical Associates

SUMMARY OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information according to the Health Information Portability and Accountability Act (HIPAA).

Uses and Disclosures of Health Information We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law;
- To a collection agency and may provide protected health information to that agency in the event you do not satisfy your financial responsibilities.

Patient Rights As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please contact the office.

I, _____, acknowledge that I was provided a copy of the Notice of Privacy Practices and
(Name of patient)
that I have read or had the opportunity to read if I so chose and understood the Notice. This authorization may be revoked by me at any time in writing. By signing below, I hereby authorize Ankle & Foot Surgical Associates to obtain Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

In addition, I authorize the following person(s), _____ to access to my personal health information upon request.

Signature of Responsible Party_____ **Date**_____

Relationship (if not patient) _____