PREFERRED FOOT & ANKLE SPECIALISTS

Date:_____/_____/_____

PATIENT NAME:_____ **DATE OF BIRTH**:____/____/____ **SEX:** M F

HOME ADDRESS:_____ CITY/STATE/ZIP:_____

PATIENTS SSN:_____- _____-_____

PREFERRED PHONE NUMBER:_____ MAY WE LEAVE A MESSAGE?: YES NO

ALTERNATE PHONE NUMBER:_____ MAY WE LEAVE A MESSAGE?: YES NO

EMAIL ADDRESS:_____ TEXT REMINDERS: YES NO

PRIMARY LANGUAGE:_____ HOW DID YOU HEAR ABOUT US?_____

PRIMARY CARE PROVIDER:_____ OFFICE:_____ PHONE:_____

PREFERRED PHARMACY:_____ ADDRESS:_____ PHONE:_____

EMERGENCY CONTACT INFO:

NAME/PHONE:_____ RELATIONSHIP:_____

NAME/PHONE:_____ RELATIONSHIP:_____

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY:_____
ADDRESS:_____ CITY/STATE/ZIP:_____

MEMBER ID#:_____ GROUP#:_____

POLICY HOLDER NAME:_____ DOB:_____/_____/_____
RELATIONSHIP TO PATIENT:_____

SECONDARY INSURANCE COMPANY: :_____

ADDRESS:_____ CITY/STATE/ZIP:_____

MEMBER ID#:_____ GROUP#:_____

POLICY HOLDER NAME:_____ DOB:_____/_____/_____

RELATIONSHIP TO PATIENT:_____

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HAVE YOU EVER HAD ANY OF THE FOLLOWING?

☐ ACID REFLUX	☐ CANCER	☐ LIVER DISEASE
☐ ANEMIA	☐ DIABETES	☐ MIGRAINES
☐ ARTHRITIS	☐ HEART PROBLEM	☐ NEUROPATHY
☐ ASTHMA	☐ HEPATITIS	☐ OPEN SORES
☐ BACK ISSUES	☐ HIV/AIDS	☐ SLEEP APNEA
☐ BLEEDING	☐ HYPERTENSION	☐ STROKE
☐ BRONCHITIS	☐ KIDNEY DISEASE	☐ THYROID DISEASE
☐ OTHER: _____		

CURRENT PROBLEM:

REASON FOR VISIT: _____

WHEN DID PROBLEM FIRST START? _____ DURATION: _____

LIST ANY PRIOR THREATMENTS FOR THIS PROBLEM:_____

_____

IF APPLICABLE, DESCRIBE YOUR PAIN BY CIRCLING BELOW:

SHARP / DULL / ACHING / BURNING / RADIATING / ITCHING / STABBING

OTHER:_____

PLEASE CIRCLE ONE:

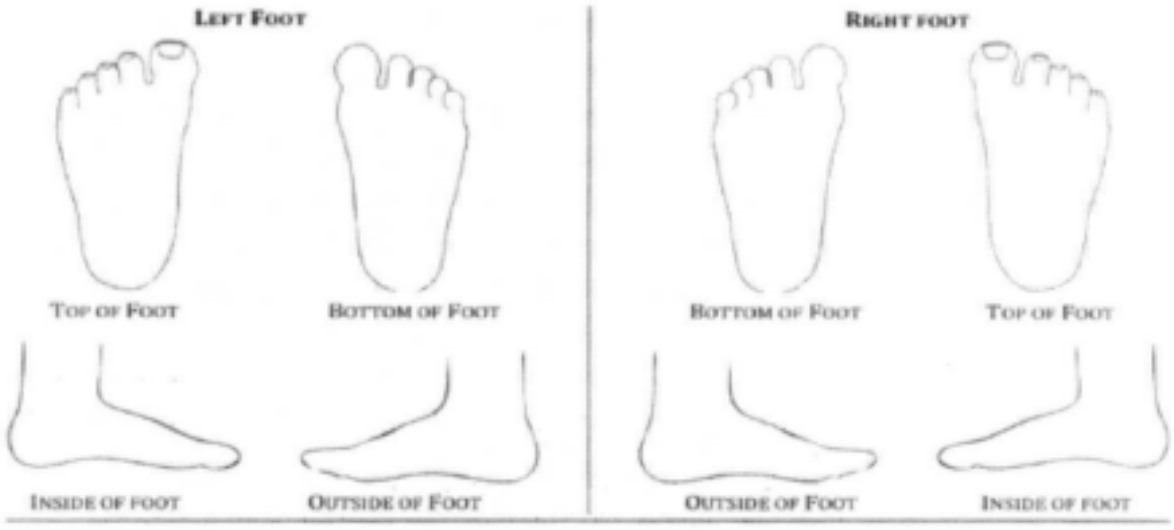
PROBLEM CAUSED BY INJURY: **YES / NO**

DOES THE PROBLEM AFFECT YOUR LIFESTYLE OR ABILITY TO WORK? **YES / NO**

WHAT MAKES THE PAIN FEEL WORSE? **STANDING / WALKING / RUNNING**

SINCE THE PROBLEM STARTED, HAS THE PAIN: **STAYED THE SAME / BECAME WORSE / IMPROVED**

USING THE DIAGRAM BELOW, CIRCLE WHERE PAIN / PROBLEM IS:



PREFERRED FOOT & ANKLE SPECIALISTS

PATIENT NAME:_____

DATE OF BIRTH:_____/_____/_____

MEDICAL HISTORY

HEIGHT:_____

WEIGHT:_____

SHOE SIZE:_____

PLEASE MARK ALL THAT APPLY:

☐ **CURRENT SMOKER**

HOW MUCH/PACKS PER DAY? _____

☐ **DRINK ALCOHOL:**

RARE | OCCASIONAL | MODERATE | DAILY

HISTORY OF ALCOHOL ABUSE? YES NO

☐ **CURRENTLY PREGNANT**

☐ **USE RECREATIONAL DRUGS: TYPE**_____

RARE | OCCASIONAL | MODERATE | DAILY

PLEASE LIST ALL KNOWN ALLERGIES:

_____ _____
_____ _____
_____ _____
_____ _____

CURRENT DAILY/SEASONAL MEDICATIONS AND DOSAGE:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

PAST SURGERIES/HOSPITALIZATIONS: (LIST MOST RECENT FIRST) :

_____ _____
_____ _____
_____ _____
_____ _____

FAMILY HISTORY:

_____ _____
_____ _____
_____ _____

PREFERRED FOOT & ANKLE SPECIALISTS

ACKNOWLEDGMENT OF PRIVACY PRACTICES

THE PRIVACY OF YOUR MEDICAL RECORDS AND PERSONAL INFORMATION IS IMPORTANT TO US. DOCUMENTATION OF YOUR INFORMATION AND MEDICAL TREATMENT/ SERVICES RENDERED ARE CREATED TO PROVIDE YOU WITH QUALITY CARE AND COMPLY WITH HIPAA GUIDELINES. PREFERRED FOOT AND ANKLE SPECIALISTS/ PEDIATRIC FOOT AND ANKLE MAY DISCLOSE INFORMATION FOR TREATMENT, OR TO HEALTHCARE PERSONNEL FOR THE PURPOSE OF CARE AND TO OBTAIN ANY AUTHORIZATION/PRE-CERTIFICATIONS.

I ACKNOWLEDGE THAT A FULL COPY OF PREFERRED FOOT AND ANKLE/PEDIATRIC FOOT AND ANKLES PRIVACY PRACTICES IS AVAILABLE ON THEIR RESPECTED WEBSITES/OFFICE CAN PROVIDE A HARD COPY AT MY REQUEST.

_____

PATIENT NAME (please print) Date

_____
Parent/Guardian/Legal Representative

_____
Signature

ANY INFORMATION YOU DO NOT WISH TO DISCLOSE MUST BE SPECIFIED IN WRITING. ANY INFORMATION BEING REQUESTED TO BE RELEASED TO ANYONE BESIDES A REFERRING/TREATING PHYSICIAN MUST BE SUBMITTED TO US IN WRITING

PLEASE LIST THE NAMES OF THOSE THAT YOU GIVE OUR OFFICE PERMISSION TO SPEAK WITH OR OBTAIN COPIES OF YOUR MEDICAL RECORD/MEDICAL CONDITION.

Name_____ Relationship to patient: _____

Name:_____ Relationship to patient: _____

Name:_____ Relationship to patient: _____

Name:_____ Relationship to patient: _____

Thank you for choosing Preferred Foot and Ankle Specialists/Pediatric Foot and Ankle as your preferred foot care provider. Your clear understanding of the financial policy agreement is important. Please read carefully and initial/sign where indicated.

1. **Insurance:** As a courtesy we will verify your benefits before your appointment. Coverage, or benefits obtained in the office are not a guarantee of payment or coverage and can change. If your insurance company does not pay the practice within 60 days, the balance will be billed to you.
   Initial: _____

2. **Proof of Insurance:** Patients are responsible for providing accurate and up-to-date insurance information **at the time of service**. Failure to do so may result in claim denial. If a claim is denied due to incorrect or incomplete insurance information, the patient will be responsible for the full claim balance.

   If secondary/tertiary insurance information is not provided at the time of service or prior to claim submission, claims that have already been submitted to the primary insurance will not be refiled or resubmitted to secondary insurance. Once secondary insurance information is received, it will be applied to claims submitted going forward only.
   Initial: _____

3. **Referrals:** If a referral from your primary care physician is required by your insurance plan, it is the **patient's responsibility** to obtain a valid referral prior to the appointment. Appointments without a required referral may be canceled or converted to self-pay.
   Initial: _____

4. **Payment:** All patient financial responsibilities, including copays, coinsurance, deductibles, and self-pay charges, are due at the time of service. Copays cannot be billed and must be collected at check-in, as required by your insurance plan.

   For your convenience we accept cash, check, credit cards, and CareCredit.
   Initial: _____

   Accounts with unpaid balances after 90 days may be subject to our collections process. Accounts forwarded to the collection agency will be responsible for the fee charged by the collection agency (+ 35%) in addition to the amount due in the office.
   Initial: _____

   If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by our billing department.

5. **Non-Covered Services:** Please be aware that some podiatry or routine footcare you receive may be a non-covered service or not considered medically necessary by your insurance company. Any

service determined not covered by your plan will be patient responsibility.
Initial: _____

6. **Durable Medical Equipment (DME)** is often not covered by insurance. Our office verifies coverage for **some, but not all, DME products** that may be dispensed prior to your visit. Verification is not a guarantee of payment, as coverage and reimbursement are ultimately determined by your insurance carrier.

   If your insurance plan does not cover DME, or if coverage is limited or denied, the patient is responsible for the self-pay cost or any portion not covered as determined by your insurance plan.
   Initial: _____

7. **Pediatric Patients:** The accompanying parent or adult is responsible for any copays, deductibles or coinsurance,and/or balances **at the time of appointment. Please refer to our Divorced or Separated Parents Policy if applicable.**
   Initial: _____

8. **Missed Appointment Policy**: We kindly request at least 24 hours' notice for any appointment cancellations or rescheduling. Failure to provide proper notice may result in a **$75 missed appointment fee**.
   Initial: _____

   Patients who repeatedly reschedule appointments may be required to submit a **$50 deposit** to secure future appointments. After **three (3) missed appointments or late cancellations**, the practice reserves the right to discharge the patient from the practice.
   Initial: _____

9. **FMLA/Disability**: Completion of FMLA, disability, or other administrative forms—**excluding work notes and school notes**—is subject to a **$25 processing fee**. The standard turnaround time for these forms is **one (1) week**.
   Requests requiring expedited completion will incur an **additional $25 rush fee**.
   Initial: _____

   I have fully read and understand the financial policy set by Preferred Foot and Ankle Specialists, and agree that the terms of this financial policy may be amended by the practice at any time without prior notification.

_____
Printed name of patient or guarantor

_____ Date:_____
Signature of patient or guarantor