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:_______________________________________________

PREFERRED FOOT & ANKLE SPECIALISTS

**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:**

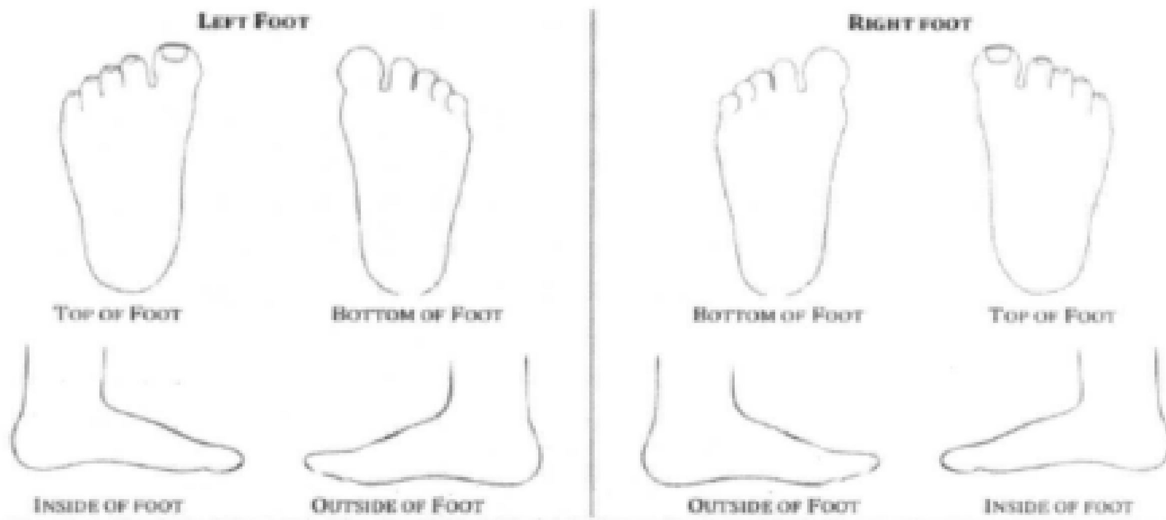
PROBLEM CAUSED BY INJURY: **YES / NO**

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:**



**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:**

____________________ ____________________
____________________ ____________________
____________________ ____________________

# 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. We are committed to providing you the best care possible. Your clear understanding of the financial policy agreement is important. Please read carefully and initial and sign where indicated. A copy will be provided for you upon request.

**Insurance:** As a courtesy we, Preferred Foot & Ankle Specialists/Pediatric Foot and Ankle will verify your benefits. Your insurance policy is a contract between you and your insurance including co-pays, deductibles, coinsurance, and non-covered services. Coverage, benefits, and quotes given 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 owed will automatically be billed to you.
**Initial: ____________**

**Proof of Insurance:** We will bill your insurance with the information you provide us. Your failure to provide us with the accurate information could result in claim denial. If this occurs you assume responsibility for the entire amount of the claim. If we later receive payment from your insurance, we will refund any overpayment. If required, obtaining the proper referral from your primary care physician is your responsibility. Failure to have a valid referral means the patient will be responsible for paying in full or reschedule the appointment. **Initial: ____________**

**Co-pays & Deductibles:** All copays, deductibles, and coinsurance are due at time of service. We do not bill for co-pays. This arrangement is part of your contract with your insurance company. Failure to collect dues at time of service can be considered as fraud. **Initial: ______________**

**DME:** If any DME(cam boot/night splint/ankle brace) is prescribed/dispensed at time of service, we collect our adjusted fee per your insurance. If any overpayment is made, you will be issued a refund once the claim has been processed with your insurance company. **Initial: _____________**

**Payment:** Payment is expected at the time of your visit. Our office accepts cash, check, credit, and care credit. Payment will include any unmet deductible, coinsurance, copayment, and non-covered charges from your insurance company. After 90 days of non-payment, accounts may be subject to our collections process. **Initial: _____________**

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

**Non-covered services:** Please be aware that some or all the services you receive may be non covered or not considered medically necessary by your insurance company. Any service determined not covered by your plan will be your responsibility. **Initial:______________**

**Pediatric Patients:** The accompanying parent or adult is responsible for any payment for copays, deductibles, or coinsurance amounts at time of appointment. **Initial:_____________**

**Missed Appointments:** We appreciate a 24-hour advance notice in any appointment cancellation or reschedule. Failure to notify will result in a $50 no-show fee. Multiple no shows or cancellations could result in a $75 fee.
**Initial:______________**

**Forms/Documents:** Any FMLA/disability paperwork, and/or extra forms that are to be completed by the providers will result in a $25 completion fee. This excludes any work notes/school notes.
**Initial: _____________**

**I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY PREFERRED FOOT AND ANKLE SPECIALIST/PEDIATRIC FOOT AND ANKLE. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTIONS IN ADDITION TO THE ORIGINAL AMOUNT DUE. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE GUARANTOR.**

______________________________________________________________________________

*Printed name of patient or responsible party*

______________________________

*Date*

______________________________________________________________________________

*SIGNATURE of patient or responsible party*