  
**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:** \_\_\_\_\_

**HAVE YOU EVER HAD ANY OF THE FOLLOWING?**

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

**CURRENT PROBLEM:**

REASON FOR VISIT: \_\_\_\_\_

WHEN DID PROBLEM FIRST START? \_\_\_\_\_ DURATION: \_\_\_\_\_

LIST ANY PRIOR TREATMENTS FOR THIS PROBLEM: \_\_\_\_\_

IF APPLICABLE, DESCRIBE YOUR PAIN BY CIRCLING BELOW:

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

**OTHER:** \_\_\_\_\_

**PLEASE CIRCLE ONE:**

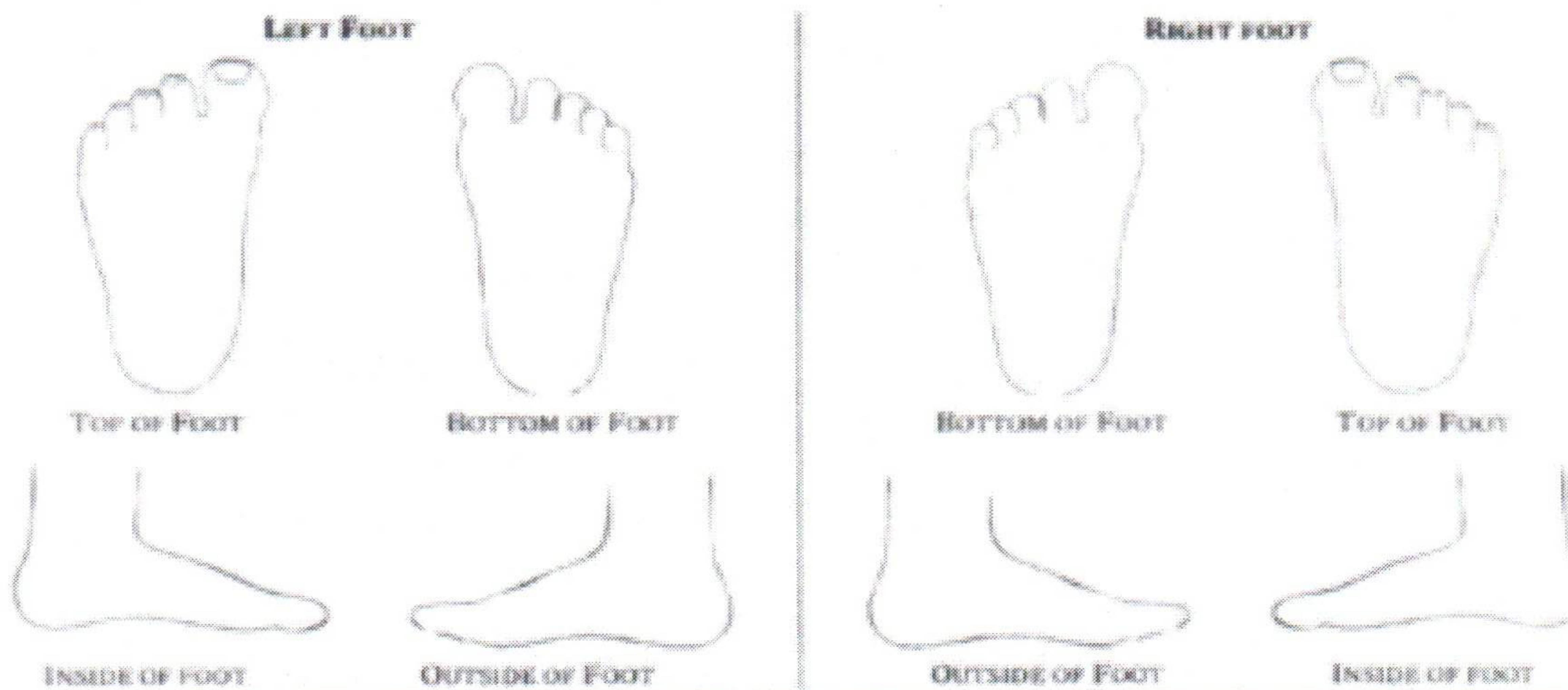
PROBLEM CAUSED BY INJURY: **YES / NO**

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:**

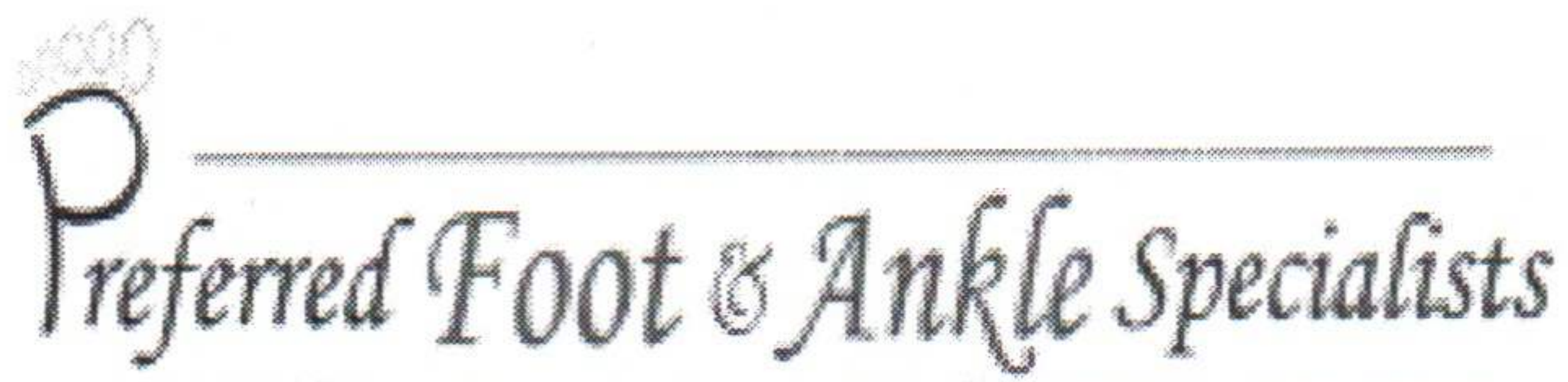
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**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.

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PATIENT NAME (please print) Date

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Parent/Guardian/Legal Representative

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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

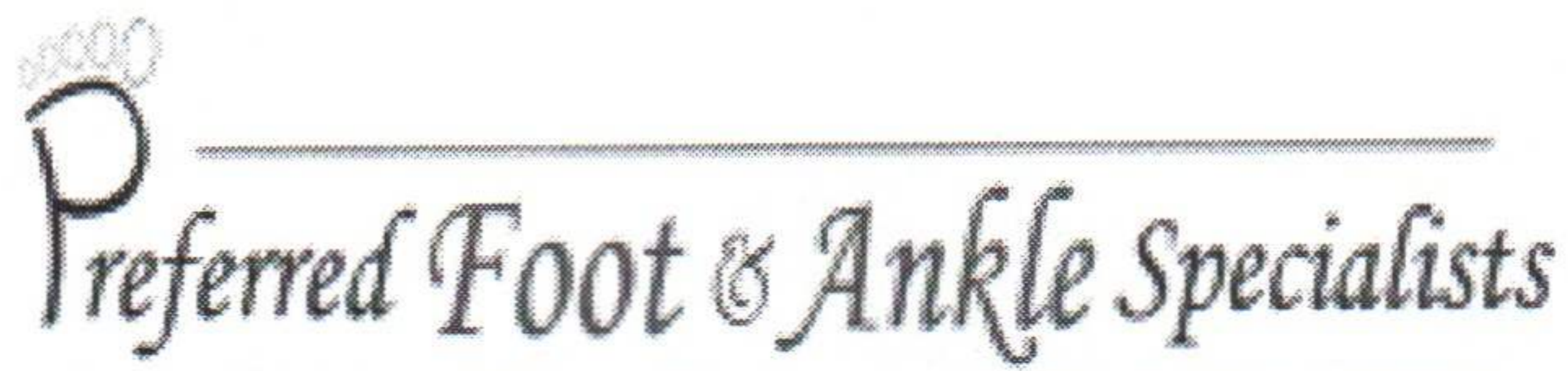
**PLEASE LIST THE NAMES OF THOSE THAT YOU GIVE OUR OFFICE PERMISSION TO SPEAK WITH OR OBTAIN COPIES OF YOUR MEDICAL RECORD/MEDICAL CONDITION.**

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_



## **FINANCIAL POLICY**

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:** \_\_\_\_\_

  
Preferred Foot & Ankle Specialists

**Missed Appointments:** We appreciate a 24-hour advance notice in any appointment cancellation or reschedule. Failure to notify will result in a \$25 no-show fee. Multiple no show 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.**

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*Printed name of patient or responsible party*

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*Date*

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*SIGNATURE of patient or responsible party*