



# The Foot & Ankle Center

## PATIENT INFORMATION

All information given is Confidential. Please fill out completely and sign below

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

SSN # \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

SEX:  Male  Female Name you go by \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email Address \_\_\_\_\_

**MARITAL STATUS:**  Single  Married  Divorced  Widowed

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Name \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

### PHARMACY

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Medications \_\_\_\_\_

### SPOUSE INFORMATION (OR PARENT IF MINOR)

Spouse /Parent Name \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

### If Minor - RESPONSIBLE PARTY

Who is responsible for this account? \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ Phone # \_\_\_\_\_

**How did you hear about our facility?**  Internet (Website / Facebook / Search Engine) Circle One  
 Family /Friend \_\_\_\_\_  Doctor Referral  Sign  
 Billboard  TV / Radio  Previous Patient

**CHIEF COMPLAINT TODAY** \_\_\_\_\_

### ACCIDENT OR INJURY INFORMATION

Date of Accident or Injury \_\_\_\_\_

Where the accident or injury took place \_\_\_\_\_

How Accident or Injury occurred \_\_\_\_\_

*All information given above is true and correct to the best of my knowledge.*

Signature of Patient or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

# INSURANCE INFORMATION

**Note: Please Present your Insurance Card to Receptionist**

## **PRIMARY INSURANCE**

Insurance Name \_\_\_\_\_

Member ID # on Insurance Card \_\_\_\_\_

Group Number \_\_\_\_\_

Group Name \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Policy Holder's Birth Date \_\_\_\_\_

SSN# \_\_\_\_\_

Relationship to Patient:     Self     Child     Spouse

## **SECONDARY INSURANCE**

Insurance Name \_\_\_\_\_

Member ID # on Insurance Card \_\_\_\_\_

Group Number \_\_\_\_\_

Group Name \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Policy Holder's Birth date \_\_\_\_\_

SSN # \_\_\_\_\_

Relationship to Patient:     Self     Child     Spouse

## **HMO Patients**

**YOU ARE RESPONSIBLE FOR YOUR OWN REFERRAL AND AUTHORIZATIONS.**

**Please make sure you know how many visits you have and how long they are good for. Most referrals are only good for 60 or 90 days. Please ask the receptionist before leaving or call the office to make sure your referral has not expired. If you do not have proper authorization to see the doctor, you, the patient, will be solely responsible for the cost of the visit.**

## **All Patients**

*I, hereby authorize, The Foot & Ankle Center, to release any medical records or information necessary to process this claim and any future claims that I may have. I also authorize payment of medical benefits directly to the physician and or provider as long as I am a patient. If it is necessary to involve a third party collector or an attorney for payment of services, I will be responsible for all cost of collection in the event of default. I understand that I, the patient, have a contract with my insurance company, not the doctor, and if for some unforeseen reason there is a dispute with my claim, I, the patient, will be responsible for the cost of services given to me by The Foot & Ankle Center.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

# PODIATRIC HISTORY

## ALLERGIES:

- Adhesive Tape     Aspirin     Betadine     Codeine     Demerol     Erythromycin  
 Iodine     Penicillin     Quinolones     Sulfa     Local Anesthetics     NONE  
 Other \_\_\_\_\_

## CURRENT MEDICATIONS:

Please list all medicines which you now use:

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## VITALS:

Current Weight \_\_\_\_\_ Current Height \_\_\_\_\_ What is your shoe size? \_\_\_\_\_

## ACTIVITIES *(please list any activities that you participate in)*

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## EXERCISE

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## SOCIAL HISTORY

Do You Drink Alcohol?     YES     NO

Do You Smoke?     CURRENT     FORMER     NON-SMOKER

Recreational Drug Use     YES     NO

OCCUPATION: \_\_\_\_\_

Employed     Unemployed     Retired     Disabled     Full Time     Part Time

Name of Company \_\_\_\_\_

## FAMILY HISTORY

Is there a Family History of any of these disorders?

Arthritis     Cancer     Diabetes     Gout     Heart Trouble

High Blood Pressure     Kidney     Mental     Migraines     Stroke

Continued on next page

# REVIEW OF SYMPTOMS

Please indicate if you have any of the following:

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**General:**                     Change in Appetite                     Chills                     Fatigue  
                                  Fever                                     Night Sweats                     Weakness

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**Cardiac:**                     Chest pain                     Feet Swell                     Hands Swell  
                                  Heart Attack                     Heart Murmur                     Leg Pain

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**Endocrine:**                     Diabetic Type I                     Diabetic Type II                     Thyroid Problems

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**GI:**                             Abdominal Pain                     Gallbladder                     Indigestion  
                                  Liver Trouble                     Nausea                             Stomach Trouble

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**Genitourinary:**                     Bladder Trouble                     Frequent Urination                     Kidney Disease  
                                  Kidney Stones                     Prostate Trouble

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**Hematologic/Lymphatic:**  Anemia                             Excessive Bleeding                     Aspirin Use

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**Musculoskeletal:**                     Arthritis                             Back Pain                             Bone Pain  
                                  Fractures                             Joint Pain                             Muscle Pain  
                                  Sprains                                 Stiffness

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**Neurologic:**                     Dizziness                             Headache                             Numbness /Tingling  
                                  Paralysis                             Seizures

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**Peripheral Vascular:**                     Blood Clots                     Cramps                     Poor Circulation                     Varicose Veins

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**Psychiatric:**                     Depression                             Other\_\_\_\_\_

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**Respiratory:**                     Asthma                                 Lung Problems                     Shortness of Breath  
                                  Sinus Problems                     TB Exposure

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**Rheumatology:**                     Fibromyalgia

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**Skin:**                             Bruising                             Deformed Nails                     Discoloration of Nails  
                                  Itching                                 Rashes                                 Scarring Tendencies  
                                  Skin Ulcerations

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**Other:**                             Hearing Loss                             Vision Loss                             Fibromyalgia

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None of the above pertains to me.



# The Foot and Ankle Center

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

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Print Name of Patient

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Signature of Patient, Parent or Authorized Representative

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Date

# The Foot and Ankle Center

## **FINANCIAL POLICY**

Thank you for choosing The Foot & Ankle Center as your healthcare provider. We are committed to the successful treatment of your condition. Please understand that payment of your bill is considered part of your treatment. Should you have any questions regarding any aspect of your financial status with our office, please feel free to contact our billing dept at 618.344.4449.

Your clear understanding of our Financial Policy is important to our professional relationship.

WE ARE HAPPY TO BILL YOUR INSURANCE DIRECTLY; HOWEVER, WE MUST HAVE A COPY OF THE INSURANCE CARD.

IF YOU DO NOT HAVE YOUR INSURANCE CARD WITH YOU, FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, OR CREDIT/DEBIT CARD.

ALL PATIENTS MUST COMPLETE OUR "PATIENT REGISTRATION FORM" AND OTHER RELATED FORMS.

PLEASE NOTIFY US IMMEDIATELY OF ANY CHANGES IN YOUR INSURANCE OR COVERAGE.

### **SELF PAY Patients**

We expect payment at the time of service unless prior arrangements have been made.

### **MEDICARE Patients**

We accept Medicare assignment. As a Medicare patient, you are responsible only for the deductible if you have supplemental insurance. A few services and supplies are not covered by Medicare. We will advise you of any non-covered charge prior to the service being provided.

### **HMO/PPO Patients**

ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE. We are members of most, but not all plans; you are responsible for verifying that we are providers for your plan. If you are an HMO member, you will not be billed as long as we have the necessary referrals. Please note: You must have your referral at the time of the visit or your plan requires that we ask you to reschedule. PPO patients will only be responsible for their deductible, co-payments and co-insurance, as long as they have verified with their insurance that our physician is in their plan.

### **WORKERS' COMPENSATION**

If you are here because of a work related injury, we will require information regarding both health insurance and your employer's Workers' Compensation carrier authorizing your treatment. The letter should include the claim number, address, adjuster's name and phone number. (Your employer's human resource office should be able to assist you with obtaining this information). If payment is not received from the third party within 90 days, we have the right to bill you directly.

### **HOSPITAL AND SURGERY CENTER CHARGES**

In the event that you undergo surgery in a hospital or ambulatory surgery center, a separate charge will be made by that facility. Your podiatric physician at The Foot & Ankle Center may have a financial interest in a surgery center where you will be having your surgery.

### **FINANCIAL AGREEMENT**

I understand that I am financially responsible for all charges not covered by insurance and I guarantee the balance to be paid by my credit card, check or cash. Past due balances may be subject to additional fees.

I understand that if the office agrees to bill insurance as a courtesy, I must submit proper information as needed to ensure payment for services rendered to me. I understand that I am ultimately responsible for payment for all services. If payment is not received from the insurance carrier or other responsible party in 90 days, I will be billed directly.

I will pay unpaid balance by: \_\_\_\_\_Cash \_\_\_\_\_Check \_\_\_\_\_Credit Card

\_\_\_\_\_  
**Name of Patient (please print)**

\_\_\_\_\_  
**Signature of Patient or Responsible Party**

\_\_\_\_\_  
**Date**



# Release of My Protected Health Information

Please **print** below information:

I, \_\_\_\_\_ hereby authorize release of my Protected health information for verbal discussion only of my care and treatment to the person(s) specified below:

Authorized family member or person to receive information for the above named patient's care:

_____	_____	_____
Name of Central Contact, other than patient	Relationship to Patient	Phone Number

Others authorized to receive my verbal information (please list names and relationship):

_____	_____	_____
Print Name	Relationship to Patient	Phone Number

_____	_____	_____
Print Name	Relationship to Patient	Phone Number

NOTE: This form does give the above referenced persons permission to make health care decisions for the patient or entitle them to paper copies or electronic access of your medical record. We will not release via the telephone or any other means of communication any information to any friends or family members not listed above unless the patient has an opportunity to object and does not (documented), or if it is reasonable to infer that the patient does not object such as when a patient brings a spouse into the room when treatment is being discussed. Exception: if the release is needed in emergency situations. Please answer both questions.

- Leave a detailed message on answering machine or voice mail?      Yes      No
- Leave a message with another person to return call?              Yes      No

Note: By signing and dating this Protected Health Information Authorized Person(s) form, I revoke all previously signed Protected Health Information Authorized Person(s) forms.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Personal Representative: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Note: Except to the extent that action has already been taken in reliance on this Protected Health Information Authorized Person(s), at any time I can revoke this Protected Health Information Authorized Person(s) by submitting a new Protected Health Information Authorized Person(s) form or by written notice to The Foot & Ankle Center where my medical records are kept.