ankle&foot CENTERS OF AMERICA
A Step Ahead

Patient Last Name:	First Name:	Middle Initial:
I Prefer To Be Called:		☐ Male ☐ Female
Address:		City:
State:	Zip: _ _ _ _ _ _ _ _ _	Email address:
Pharmacy Name: Pharmacy Address:		Pharmacy Phone:
Preferred Phone #: ☐ Cell ☐ Home ☐ Work	Other Phone #: ☐ Cell ☐ Home ☐ Work	
Date of Birth:	Age:	SSN:
Marital Status: ☐ Divorced ☐ Legally Separated ☐ Life Partner ☐ Married ☐ Single ☐ Widowed ☐ Other		
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic	Language: ☐ English ☐ Spanish ☐ Korean ☐ Other	
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White/Caucasian ☐ Decline		
Employer:	Occupation:	Work #:
Employer Address:		
Primary Care Physician Name:	PCP Phone #:	Date Last Seen:
Spouse's Name / Parent or Guardian Name if a Minor:		

Medical Insurance Information

Primary Insurance:		
Primary PolicyHolder's Name:	Date of Birth:	Relationship toPatient:
Policy Holder's Address:		
Policy Holder's Phone #:	Employer Name:	
Member ID #:	Group ID #:	SSN:
Secondary Insurance:		
Secondary PolicyHolder's Name:	Date of Birth:	Relationship toPatient:
Policy Holder's Address:		
Policy Holder's Phone #:	Employer Name:	
Member ID #:	Group ID #:	SSN:

Emergency Contact Information

Person to Notify In case of Emergency:		Relationship to Patient:
Home #:	Cell #:	Work #:

Referred by: ☐ Physician_____ ☐ Patient_____

☐ Yellow Pages ☐ Insurance Co. (☐ Web or ☐ Book) ☐ Other _____

Patient Name (Please Print) Date

Parent or Authorized Representative (if applicable) Signature

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MEDICAL HISTORY

Patient's Name: _____ **Date of Birth**: _____

Pharmacy Name:_____**Pharmacy Address:** _____

Pharmacy Telephone#:_____**Shoe Size:**_____**Height:**_____**Weight:**_____

What is your primary foot and/or ankle complaint today? _____

When did this start?_____days_____weeks_____months_____years? Is this problem getting better/worse/unchanged?

Was this the result of trauma? ☐YES ☐NO
Does this affect your walking? ☐YES ☐NO
Was this a job related injury? ☐YES ☐NO
Does this affect your ability to exercise? ☐YES ☐NO
Does this affect your daily activity? ☐YES ☐NO
If so, what exact date did injury occur?_____

How would you describe your pain? (check all that apply)
☐ generalized ☐localized ☐ throbbing ☐ radiating ☐ burning ☐ numbness ☐dull ache ☐sharp ache ☐other _____

Rank the severity of your pain: 1 2 3 4 5 6 7 8 9 10 (severe)

What treatments have you tried for this problem? _____

Do you have any other foot and/or ankle problems? _____

Are you Diabetic? ☐YES ☐NO Do you use Insulin? ☐YES ☐NO Date you were diagnosed:_____

What is your average blood sugar reading?_____ **What was your last A1C reading?** _____

Have you ever had any of the following? (check boxes that apply)

☐ Allergies
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bleeding Abnormality
☐ Cancer/Tumor
☐ Circulatory Problems
☐ COPD/Emphysema
☐ Diabetes
☐ Epilepsy/Seizure
☐ Heart Disease
☐ Hepatitis or Liver Disease
☐ High Blood Pressure
☐ HIV/AIDS
☐ Kidney Disease/Imparied
☐ MRSA
☐ Sickle Cell
☐ Skin Rash/Hives
☐ Skin Ulcer
☐ Stomach Ulcers
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Neuropathy
☐ Bunion(s)
☐ Callus(es)
☐ Other _____

CURRENT MEDICATIONS *IF YOU HAVE A LIST WE CAN MAKE A COPY*		
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements.		
Name of Drug	**Dose (strength & number of pills per day)**	**How long have you been taking this Drug?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Have you been treated by a podiatrist before? ☐ **YES** ☐ **NO**

If yes, please list the name of the podiatrist:_____ **Date of last visit:** _____

ALLERGIES (please check) If yes, list reaction			
	YES	**NO**	**Reaction**
Tape/Adhesives			
Iodine			
Latex			
Nickel/Metal			
NSAIDS/anti-inflammatories			
Penicillin			
Sulfa drugs			
Contrast dye			
Other (specify)_____			

Are you pregnant: YES ☐ NO ☐ *NOTE: we may take x-rays during your visit, so please inform us if there is a chance you may be pregnant. Also, medications we may prescribe (i.e. antibiotics) could change the effectiveness of birth control medications.

Please list all major surgeries you have had and the dates performed:

FAMILY HISTORY

Please note family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	**YES**	**NO**	**RELATIONSHIP TO YOU**
Cancer	☐	☐	_____
COPD/Lung Disease	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
Hypertension	☐	☐	_____
Stroke	☐	☐	_____
Other (specify) _____	☐	☐	_____

SOCIAL HISTORY

Do you smoke cigarettes? ☐ YES ☐ Never Smoked ☐ Former Smoker, quit date? _____

Do you use any of these tobacco products: ☐ Cigars ☐ Pipes ☐ Chewing Tobacco ☐ Snuff

Alcohol Use: ☐ Never ☐ 2-3 times per month ☐ 2-3 times per week ☐ 2-3 times per day

Do you use recreational drugs? ☐ YES ☐ NO If yes, what type: _____

I understand the completeness and accuracy of this information is critical to receiving safe and effective medical care and I have completed the form to the best of my ability. I understand that it is my responsibility to inform Ankle & Foot Centers of America of any changes to my medical status. I hereby consent and authorize Ankle & Foot Centers of America and staff to perform any service deemed appropriate by attending physician(s) to make a thorough diagnosis. I alsoauthorize Ankle & Foot Centers of America and staff to perform any procedures, forms of treatment, medication and therapy in connection with my diagnosis and treatment plan.

_____

Patient Name (Please Print) Date

_____

Parent or Authorized Representative (if applicable) Signature

FINANCIAL POLICY

Thank you for choosing **Ankle & Foot Centers of America** as your ankle and foot care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our financial policy is important to our professional relationship. Please understand that payment for services is part of that relationship. Payment will be due at the time services are rendered. In order to serve you better, we accept Cash, Check, Money Order, Care Credit, and all major Credit Cards. In our ongoing effort to make sure that all your medical needs are met, our staff is available to discuss our fees, policies, and your responsibilities with you. We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to your scheduled visit**.**

- Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is your insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

- Certain health insurances (HMO, POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

- Fees for services, which include, unpaid balances, deductibles, co-payments, co-insurances, and non-covered over the counter products are due at the time of service unless previous arrangements have been made with a billing coordinator. Absolutely no post-dated checks will be accepted. You understand and agree that if you fail to make payments for which you are responsible in a timely manner; such default will result in referral to a collection agency. In the event your account is turned over to our collection agency, you agree to pay a fee of **$35.00**.

- The charge for a returned check is **$35.00** payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check. Unpaid returned check fees and balances will be subject to collection placement.

- Our practice offers Magnetic Resonance Imaging (MRI), Physical Therapy, Pathology, and Ambulatory Surgical Centers medical services. As with other professional services, we will bill your insurance for these services; however, should your insurance not cover the charges, you may ultimately be held financially responsible.

- Completion of Forms (e.g. Disability or Family Medical Leave) and Copies of Medical Records are not a billable reimbursement by insurance carriers. Therefore, you are responsible for the **$35.00 fee** related to the completion of these documents. Payment is due when forms are presented for completion.

- When you schedule an appointment, we set aside enough time to provide you with the highest quality care. If you should need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. Any established patient, who fails to show for an appointment and has not contacted our office with at least 24 hours' notice is considered a No Show and may **potentially** be charged a $50.00 fee.

This financial policy helps Ankle & Foot Centers of America provide quality care to our valued patients. If you have any questions or need clarification regarding any of the above policies, please feel free to contact our billing department at 770-716-8732.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW

Print Name of Patient_____ Date _____

Signature of Patient or Responsible Party_____

Name and Relationship if other than patient _____

Payment Processing Authorization Form

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

- I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.
- Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.
- This practice may deny service or charge a service fee for failure to pay a co-pay at the time of service.
- It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.
- I agree to provide the above practice and/or its designated payment agent with my debit/credit card or ACH information.
- I understand that my signature and payment information will be maintained on file digitally for future use by the practice. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or ACH Information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.
- If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that I may incur some interest expense beyond my balance in exchange for this convenience. I can avoid interest charges by paying my bill immediately if required or by its due date.
- I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or ACH account for all amounts owed to the practice for medical visits, procedures or supplies, including (I) amounts agreed as part of a payment plan, (II) copayments, (III) coinsurance (after application of insurance proceeds), (IV) amounts not covered by insurance and/or (V) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
- In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.
- Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.
- I authorize the above practice and/or its designated payment agent to send electronic account statements and invoices to my email address on file and to contact me by phone concerning any account balance. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

Name as it Appears on Card/Check _____ **Email Address** _____

Billing Address _____ **City** _____ **State** _____

AUTHORIZED SIGNATURE _____ **Date**

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

Patients:

To ensure your privacy, please answer the following questions and notify the Front Office Staff whenever this information change.

1. Do we have permission to leave a message on the phone number(s) you have provided to us?

YES ☐ or NO ☐

2. May we discuss your Medical Information with family andfriends?

YES ☐ or NO ☐

OR:

Please list names of people we can discuss your medical care with:

Name:_____ Phone #:_____

Patient's Relationship to contact: ☐ Spouse ☐ Parent ☐ Child ☐ Friend

Name:_____ Phone #: _____

Patient's Relationship to contact: ☐ Spouse ☐ Parent ☐ Child ☐ Friend

Name:_____ Phone #: _____

Patient's Relationship to contact: ☐ Spouse ☐ Parent ☐ Child ☐ Friend

3. If someone calls for you or asks for you while you are in our office, do we have permission to tell the individual you are here? YES ☐ or NO ☐

_____ _____

Patient Signature Original Date

_____

Patient Name (Printed)

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (Please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

SUMMARY OF NOTICE OF PRIVACY PRACTICES

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.

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 healthinformation;
- To receive notice of our privacy practices.

If you have a question, concern, or complaint regarding our privacy practices, please inform your Doctor.