PATIENT REGISTRATION FORM Today's date_____

Last Name_____ First Name _____ MI_____

Social Security#_____ Date of Birth _____ Age _____

Gender_____ Martial Status_____

Race (Optional): *Please Circle* BLACK WHITE ASIAN HISPANIC AMERICAN INDIAN OTHER

Address_____Apt/Unit#_____

City_____ State_____ Zip_____-_____

Home Phone_____ Cell phone_____ Work Phone_____

Employer _____ Occupation _____

How did you hear about us? Personal Reference _____ Internet _____ Yellow Pages _____ Other _____

If a physician referred you to our office please provide the name: _____

Would you like access to the online patient portal? ☐ Yes ☐ No Email_____

You will receive an email with instructions on how to create an account on a secured website.

EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone _____ Cell Phone _____

INSURANCE INFORMATION

Primary Insurance Company Name _____ Phone number_____

Policy Holders Name *(if other than self)* _____ Relationship _____

Social Security # _____ Date of Birth _____

Policy/Member # _____Group # _____

Employer Providing Insurance_____

Secondary Insurance Company Name _____ Phone number _____

Policy Holders Name *(if other than self)* _____Relationship _____

Social Security # _____ Date of Birth _____

Policy/Member # _____ Group # _____

Employer Providing Insurance _____

PRIMARY CARE DOCTOR

Name _____

Phone#_____

Date last seen _____

PREFERRED PHARMACY

Name_____

Phone#_____

PATIENT MEDICAL INFORMATION

SHOE SIZE: _____ HEIGHT: _____ WEIGHT: _____

What is the reason for your visit today? _____
Is this related to an injury/accident? □ YES □ NO
What type of injury/ accident were you involved in? □ Worker's Comp □Auto □Slip and fall
Date of injury: _____
Please provide our office with any additional information if available.

Are you experiencing pain or discomfort? □ YES □ NO What is your pain level? _____ (1- no pain, 10- severe)
Where is your pain/ discomfort located? _____

MEDICATION HISTORY

Please list your medications here:

_____
_____
_____
_____
_____
_____
_____
_____
_____

(Use the back of this page for more space.)

Please list any medication allergies here:

_____
_____
_____
_____
_____

NO KNOWN MEDICATION ALLERGIES.
Circle above if you have NO medication allergies.

FOR DIABETICS
When was your most recent A1C?
date: _____ results: _____
Name of your optometrist or ophthalmologist:
_____

Do you currently use tobacco? □ YES □ NO
Do you currently use alcohol? □ YES □ NO
I have used tobacco/ alcohol in the past. □ YES □ NO

IMMUNIZATION HISTORY

Have you had the following?			Date:
Tetanus	□ YES	□ NO	_____
Flu vaccine	□ YES	□ NO	_____
Pneumonia	□ YES	□ NO	_____

SURGICAL HISTORY

Please list your surgeries here starting with recent:

_____
_____
_____

(*Use the back of this page if more space is needed.)*

PATIENT AND FAMILY HISTORY

Please circle **"P"** for any condition that pertains to you (the patient) and circle **"F"** for any condition that pertains to your (the patient's) mother or father.

AIDS/HIV	P	F	Diabetes	P	F	Heart Disease	P	F
Anemia	P	F	Dizzy Spells	P	F	Hepatitis	P	F
Arthritis	P	F	Epilepsy	P	F	High Blood Pressure	P	F
Asthma	P	F	Fainting	P	F	High Cholesterol	P	F
Bleeding Disorder	P	F	Fibromyalgia	P	F	Kidney condition	P	F
Cancer	P	F	Gastro-intestinal Disorders	P	F	Neuropathy	P	F
Chest Pain	P	F	Glaucoma	P	F	Varicose Veins	P	F
Circulation condition	P	F	Gout	P	F	Tuberculosis	P	F

List any other medical conditions not listed above and to whom it pertains to either the patient (P) or family (F).

_____
_____

PATIENT REGISTRATION continued

PROTECTED HEALTH INFORMATION DISCLOSURE

We cannot discuss your Protected Health Information (PHI) with anyone than yourself unless you authorize us to do so. Please list below the name(s) of the individual(s) you authorize our office to discuss your care with. Your PHI will be disclosed to the individual(s) listed below until you notify us otherwise in writing.

Name _____Date of Birth _____
Name _____Date of Birth_____
Name _____Date of Birth _____

This authorization will remain in effect for one year unless otherwise specified. I understand this authorization extends to all or any part of my medical records. I expressly consent to the release of information as designated above. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained.

INSURANCE AUTHORIZATION, RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize Ankle & Foot Associates to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. It may be used to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested the medical service of Ankle & Foot Associates on behalf of myself and/or dependents, and I understand by making this request, I become fully financially responsible for any and all charges occurred in the course of the treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, Medigap, Medicaid, private insurance and any other health/medical plan to issue payment directly to Ankle & Foot Associates, for medical service rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand I am responsible for any amount not covered by insurance, regardless of insurance coverage.

INITIALS

NOTICE OF PRIVACY

I acknowledge that upon request I received a copy of the Ankle & Foot Associates “Notice of Privacy Practices”. I have read and understand all of the above and agree to comply.

INITIALS

CONSENT TO TREAT

The purpose of medical care is to facilitate the treatment of disease, injury and disability. Medical services are provided through examination, testing and use of procedures to the aid of diagnosis or treatment of a medical condition. I request and authorize Ankle & Foot Associates to provide me with medical services as described above. I agree to cooperate fully and to participate in all medical procedures and to comply with the plan of medical care/services that is established.

INITIALS

RESPONSIBLE PARTY (Adult present signing consent to treat if the patient is a minor or Power of Attorney is necessary)

Last Name _____ First Name _____ MI _____
Patient Relationship to Responsible Party _____
Social Security# _____ Date of Birth _____
Address _____ Apt/Unit# _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____

OUR MEDICATION POLICY

All medication request may take up to ***48 hours to be processed***. If the medication is a narcotic it **cannot** be called into the pharmacy, therefore, the patient must pick up from the office once processed. If you have not see the doctor within 10 weeks an appointment will have to be made in order to have your prescription refilled. Initialing here indicates that you understand this policy.

INITIALS

FINANCIAL POLICY

The doctors and staff at Ankle & Foot Associates would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible.

BY SIGNING BELOW YOU CONFIRM THAT YOU HAVE READ THIS POLICY AND UNDERSTAND THE FOLLOWING:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current----accordingly, all self pay or insurance co-payments, co-insurance and deductibles will be collected ***at the time of services.*** Payable by: cash, check, Visa, MasterCard, Discover or American Express.
- If you do not have payment(s), your appointment may be rescheduled.
- A returned check will result in a $25 service charge and all future payment being required in the form of cash or credit card.
- There is a $25 charge for the completion of paperwork (ex: disability, FMLA, etc)
- Any unpaid balances older than 30 days may be subject to 1.5% interest per month
- If your account is turned over to collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court cost and attorney fees.
- If unable to keep your appointment, please notify us in advance so that we may offer that time to another patient.
- A pattern of repetitive "No show" or late cancellations may regretfully result in an assessment of a cancellation/no show fee of $30.00

IF YOU HAVE HEALTH INSURANCE COVERAGE:

We will submit your claims, however ***we must emphasize that as medical providers, our relationship is with you, not your insurance company.*** Although we attempt to verify your benefits with your insurance policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of inquiry.

BY SIGNING BELOW YOU CONFIRM THAT YOU UNDERSTAND THE FOLLOWING:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- If your insurance policy requires a referral from your primary care physician, it is your responsibility to have that referral faxed to our office prior to your appointment.
- Not all services are covered benefits with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
- You are responsible for any non-covered charges not payable by your insurance policy.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. ***We are here to help you.***

I have read and understand the above Financial Policy and agree to meet all financial obligations.

_____ _____

Patient Signature Responsible Party Signature (if other than patient)

_____ _____

Date Date