

Associates in Foot & Ankle Surgery, LLC
www.brickfootdoctors.com

Date _____

Patient Information

Name _____ M / F D.O.B _____ Age _____
Home Phone _____ Cell Phone _____ Soc. Sec# _____ - _____ - _____
Address _____ City _____ State _____ Zip _____
Emergency Contact _____ Phone _____ Relation _____
Email: _____

Guarantor Information

Person responsible for Account _____
Relation to patient _____ D.O.B _____ Soc. Sec# _____ - _____ - _____
Address (if different than patient) _____ Phone _____
Employed By _____ Occupation _____
Business Address _____ City _____ State _____ Zip _____

Is this an Injury ? Y / N

Date of Accident _____ Type of Accident _____ Employment related? _____

Insurance Information

Must present updated copy of Insurance cards

Primary Insurance _____

Insured's Name _____ Insured's D.O.B _____

Insured's Soc. Sec# _____ - _____ - _____ Relationship to Patient _____

Secondary Insurance (if any) _____

Insured's Name _____ Insured's D.O.B _____

Insured's Soc. Sec# _____ - _____ - _____ Relationship to Patient _____

Assignment and Release

I, the undersigned, hereby certify that I (or my dependent), has insurance coverage with the above noted insurance company and assign benefit payments directly to Associates in Foot & Ankle Surgery, LLC. I understand that I am financially responsible for all services rendered. I hereby authorize the doctor to release any information necessary to secure payment. I authorize the use of this signature on all insurance submissions. I also understand that it is my responsibility to inform the office if there is a change in my health insurance information that I've provided.

Signature _____ Relationship _____ Date _____

Patient Medical History

Date _____

Name _____ D.O.B _____

Primary Care Physician _____ Phone _____

Are you presently under the care of a physician? Y / N

If yes, for _____

Please list any and all medications: _____
(or provide list to be copied)

Pharmacy Name & Location _____

Do you have any allergies? Y / N

If yes, please list _____
(examples: penicillin, lidocaine, codeine, aspirin, food, tape)

Do you smoke? (please circle) Yes No

Shoe size _____ Weight _____

Present/ Previous Illnesses

****Check all that apply****

- | | |
|----------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eye Problems |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Rheumatic Fever Year ____ | <input type="checkbox"/> Cortisone Treatment |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cholesterol |

Are you or could you be pregnant? Y / N

Have you been Hospitalized and/or had any Surgeries in the past five years? Y / N

If yes, for _____

What problems are you presently having with your Feet and/or Ankles?

How did you learn about our practice? _____

FINANCIAL POLICY FOR ASSOCIATES IN FOOT & ANKLE SURGERY, LLC

Thank You for choosing our practice to take care of your podiatric needs. We are committed to serving you with high quality care. Letting you know in advance of our office policy allows for a good flow of communication. If you have any questions please do not hesitate to ask a member of our staff.

APPOINTMENTS: We believe your time is as valuable as ours. If you are running late to your appointment , please contact our office as soon as possible. If you are more than 15 minutes late you risk your appointment being rescheduled. There is a NO SHOW fee of \$25 which is not covered by insurance and your responsibility.

INSURANCE: We participate with most insurance plans. You will be required to present an up-to-date insurance card at each visit. It is your responsibility to know your insurance benefits. We will submit your claims and assist you in any way we reasonably can to get your claims paid. Please contact your insurance company with any questions you may have regarding coverage.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable and necessary by Medicare or other insurers. You are responsible for payment of these services.

MEDICARE: We are a participating Medicare provider. Medicare, as well as your secondary insurance, (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible. Once your deductible has been met, you are responsible for 20% of the allowed amount for an item or service.

COPAYMENTS AND BALANCES: All co-payments and outstanding balances must be paid at the time of visit.

SELF PAY: Payment in full is due at the time of service.

.REFERRALS/AUTHORIZATION: If your plan requires a referral, it is your responsibility to obtain one prior to your appointment.

PATIENT BILLING: You will be sent up to three statements for your financial responsibility after notification is received from your insurance company. After the third notice, your account will be forwarded to collections and a \$50 administration fee along with 12% interest will be applied. We accept cash, check and credit/debit cards. A \$35 fee will be charged for any returned checks. In the event your insurance company should happen to send payment to you we expect that you will forward it to our office.

PRIVACY STATEMENT: In accordance with the federally mandated program, The Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed. A copy of this Notice of Privacy Practices is offered and available if you so request.

I have read and understand the above Office Financial Policy and agree to comply as outlined above.

PRINT Patient Name

Patient, Parent or Guardian Signature

Date