

PATIENT REGISTRATION

PATIENT INFORMATION

Name: _____ Date of Birth: ____/____/____
First Middle Int. Last

Social Security #: _____ Sex: M F Marital Status: _____

Address: _____
Street City State Zip

Home phone: () _____ Cell phone: () _____ Work phone: () _____

E-mail address: _____

Employer: _____ Occupation: _____

If you were referred by another physician, please indicate his/her name: _____

INSURANCE POLICY HOLDER (GUARANTOR) INFORMATION

FIRST INSURANCE:

Policy Holder Name: _____ Date of Birth: ____/____/____

Address: _____
Street City State Zip

Policy Holder Social Security #: _____ Policy Holder Employer: _____

SECOND INSURANCE:

Policy Holder Name: _____ Date of Birth: ____/____/____

Address: _____
Street City State Zip

Policy Holder Social Security #: _____ Policy Holder Employer: _____

*(If you have more than two insurances, please check here: _____)

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____

Home phone: () _____ Cell phone: () _____ Work phone: () _____

HOW DID YOU HEAR ABOUT US?

- _____ Phone book/Yellow pages
- _____ Insurance company referral
- _____ Newspaper advertisement
- _____ Internet site/search
- _____ Saw sign driving by
- _____ Radio advertisement
- _____ PCP suggested this doctor
- _____ Friend/relative was a previous patient (name): _____

OTHER

Primary Care Physician/Family Doctor: _____

Preferred Pharmacy: _____ Phone Number: _____

PATIENT MEDICAL HISTORY FORM

Patient Name: _____

Gender: M F Height: _____ Weight: _____ Current Shoe Size: _____

Please briefly state your current foot/ankle complaint:

Please answer the following to help describe the complaint:

Nature (sharp, dull, achy, burning, etc.): _____

Location (toe, top of foot, etc.): _____

Duration (how long present): _____

Onset (what caused the onset – new shoes, activity, etc.): _____

Course (intermittent, constant, progressive): _____

Aggravating factors (standing, sitting, jumping, etc.): _____

Treatment (self or professional treatment): _____

ALLERGIES: (use separate sheet of paper if necessary)

_____ I have no known drug allergies.

_____ I am allergic to the following:

MEDICATIONS - Including vitamins & over-the-counter meds: (use separate sheet of paper if necessary)

MEDICAL HISTORY:

Do you have or have you ever had/been diagnosed with any of the following medical conditions?

◇ Diabetes (circle type): Type I Type II How often do you check your blood sugar? _____ What is your average daily reading?

- | | | | |
|-------------------------------|-------------------------|-------------------------|-----------------------------|
| ◇ High Blood Pressure | ◇ Osteoarthritis (DJD) | ◇ Kidney Disease | ◇ Psoriasis |
| ◇ High Cholesterol | ◇ Rheumatoid Arthritis | ◇ Hypothyroid (low) | ◇ Eczema |
| ◇ Heart Failure | ◇ Gout/Gouty Arthritis | ◇ Hyperthyroid (high) | ◇ Basal Cell Carcinoma |
| ◇ Heart Attack | ◇ Psoriatic Arthritis | ◇ Liver Disease | ◇ Sqamous Cell Carcinoma |
| ◇ Heart Murmur | ◇ Fibromyalgia | ◇ Hepatitis A, B, or C | ◇ Melanoma |
| ◇ Stroke | ◇ Polio/Post-polio | ◇ Tuberculosis (TB) | ◇ Warts |
| ◇ Varicose Veins | ◇ Raynaud’s Disease | ◇ Asthma | ◇ Cataracts |
| ◇ Clotting Disorder | ◇ Gastric Reflux (GERD) | ◇ Emphysema | ◇ Hearing loss/hearing aids |
| ◇ Anemia or Sickle Cell | ◇ Stomach Ulcer | ◇ COPD | ◇ Rheumatic Fever |
| ◇ Edema or Lymphedema | ◇ Diverticulitis | ◇ Epilepsy | ◇ HIV or AIDS |
| ◇ Peripheral Vascular Disease | ◇ Hernia | ◇ Depression or Anxiety | ◇ RSD |

SURGERIES:

Please list all surgeries you have had –use an additional sheet if more space is needed.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

SOCIAL HISTORY:

Tobacco: No Yes How much & what kind? _____

Alcohol: No Yes How much & what kind? _____

Illicit Drugs: No Yes How much & what kind? _____

Exercise Routine: No Yes How often & type of exercise? _____

Regular Sports Activity: No Yes How often & type of activity? _____

FAMILY HISTORY:

Diabetes Who? _____ High Blood Pressure Who? _____

Heart Disease Who? _____ Stroke Who? _____

Cancer Who? _____ Gout Who? _____

REVIEW OF SYMPTOMS:

Do you experience any of the following unusual symptoms on a regular basis?

- Severe Headaches Hay Fever Difficult Swallowing Burning/Tingling Pains Skin Rash
- Dizziness Leg Cramps Difficulty Urinating Muscle Weakness Rapid Weight Loss/Gain
- Sudden Hearing Loss Chest Pain Depression/Anxiety Unusual Fatigue Blurred Vision
- Fast Heart Beat Short of Breath Severe Nose Bleeds Bleeding Gums Rectal Bleeding
- Prolonged Sore Throat Coughing Blood

OTHER:

Do you wear glasses or contacts? Yes No

Do you have a pacemaker? Yes No

Are you on dialysis? Yes No

Are you pregnant? Yes No

Are you nursing? Yes No

I hereby give the physicians of Family Foot Health Center permission to diagnose and administer treatment for my foot and ankle condition and authorize any release of information obtained in the course of my treatment.

Patient/Guardian Signature: _____

Date: _____

FINANCIAL POLICY

Thank you for choosing Family Foot Health Center as your foot and ankle health provider! With the ever changing healthcare environment, it has become necessary to set written guidelines for the benefit of our patients so that there are no misunderstandings with regard to the financial aspect of your care. Please read and sign our Financial Policy prior to your treatment. Thank you!

General Information

- * Payment in full is due at the time of service (unless other arrangements are made prior to your treatment).
- * If your insurance policy is an HMO, PPO, POS or 'third party' insurance company, the **co-pay/co-insurance** will be due at the time of service.
- * All co-pays will be collected at check-in to help facilitate a smoother checkout process.
- * Our staff will verify benefits and check your deductible status prior to services being rendered.
- * It is the responsibility of the patient/guardian to keep this office informed of insurance changes and address/phone changes.
- * We accept cash, checks, debit and credit cards (Visa, M/C, Discover).

All Patients With Insurance

- * As a courtesy, we will submit a claim for your visit to your insurance company.
- * If the insurance company deems that there is a problem with the claim, we will work with their representative to fix/change the problem as necessary and resubmit the claim. After this second submission, any denial will become the patient/guardian's responsibility and an account statement will be sent to the address we have on file for the patient.

Medicare Insurance Information

- * After your yearly deductible is met, we will accept assignment of benefits as set forth in Medicare Part B.
- * As set forth in your Medicare handbook, the co-insurance amount of 20% of Medicare's 'allowable' will be collected at the time of service if you do not have a supplemental insurance or if the supplemental insurance does not cover the service(s) rendered.
- * Medicare does not cover all services. Any non-covered service/treatment must be paid in full at the time of service. Our staff strives very hard to keep patients informed of non-covered services and will alert you prior to the service if possible.

HMO, PPO, POS, Third Party Insurance Information

- * The co-pay/co-insurance is due at the time of service (see above).
- * If you have not met your yearly deductible, the full fee for service(s) rendered will be due at the time of service.
- * You will be responsible for providing a referral, prior to treatment, if required by your insurance company. The staff will try to alert you when a referral might be needed, but with thousands of different policies it is ultimately the responsibility of the patient.
- * Even with insurance some services may be deemed 'non-covered' by your insurance and you will be responsible for these fees.

Indemnity Insurance Information

- * The staff will verify benefits prior to treatment. If you have not met your yearly deductible, you will be responsible for the full fee for services at the time of service.

Minor Patients

- * The parent/guardian/adult accompanying the minor will be responsible for payment at the time of service as outlined above.
- * This office is not a party to a divorce decree and therefore payment issues between those parties will need to be worked out independent of this office.
- * Care of a minor that is not a life-threatening emergency will not be carried out without proper consent and prior arrangements being made with the parent/guardian and this office.

Delinquent Accounts

- * All account balances that are past due ninety (90) days or more will be charged a cumulative interest rate of 10% per month.
- * Delinquent accounts will be pursued for collection by an outside collection agency. All fees associated with this process will be your responsibility.

Returned Checks

- * All checks returned by the bank for 'non-sufficient funds' will be charged a \$25.00 processing fee. This office will call you at the phone number we have on file to alert you of the bounced check.
- * The \$25.00 fee and the original check amount must be paid in full, via cash or money order, within five days of receiving the returned check. If not paid during this time, the bounced check will be turned over to the Rogers City Attorney for collection.

Refunds

- * Supplies/products sold to the patient will not be refunded. Unfortunately, every supply prescribed may not work for all patients; however, we strive to only prescribe or recommend those supplies that have shown promise with your diagnosis.
- * Patient refund balances of \$10.00 or more will be mailed to the address we have on file; lesser amounts may be picked up at the office. The credit can also be applied to a future visit at your request.

Financial Hardship

- * We do understand that temporary financial hardships can occur. We want to work with you to reach an amicable solution; however, you must inform us of the hardship. Please do not just ignore your patient statements – call us and we can usually develop a payment plan, not to exceed ninety (90) days.
- * If you do not inform us of your hardship and the account becomes 'delinquent' (past due >90 days), we must pursue our normal collection process.

ACCEPTANCE

I HAVE READ THE ABOVE FINANCIAL POLICY AND AGREE TO COMPLY WITH THE POLICY.

Patient/Guardian Signature

Relationship to patient

Date

OFFICE POLICIES

Welcome to our office! We would like to work in conjunction with you so that you have a pleasant experience during your visit(s). To help facilitate your visit and answer some of the most common questions we are asked each day, you will find our basic office policies that are in place for your benefit. Please read the policies and ask a staff member if you have any questions - thank you!

Regarding office visits:

- *New patients need to arrive at least 20 minutes prior to the scheduled appointment time. Staff must have time for completion of your chart paperwork/insurance information. If you cannot arrive early, your appointment with the doctor may be delayed behind others who have arrived in time to process paperwork. (Please factor in time for traffic delays, as this is an ever-increasing problem.)
- *Late arrivals of 10 minutes or more will be rescheduled.
- *We have a lengthy 'wait-list'. Please kindly give at least 24 hours notice if you wish to cancel an appointment. An answering service is available for messages after business hours.
- *We do try to call the day prior to remind you of your appointment. We will leave a message identifying where we are calling from unless you request that we do not do so.

Regarding medical records:

- *The original medical records generated, including x-rays, are the permanent property of the Family Foot Health Center. Per federal and state guidelines, permanent records, including x-rays, are not to be given out for any reason – copies only should be given out.
- *A request for a copy of your medical records may be made by signing a *Medical Release Form*. Allow at least 5 business days for the copies to be made after receiving the request.
- *A minimal copy charge of \$0.25/page will apply when copying paper records. This charge covers the costs associated with staff time and office supplies. X-rays may be copied at a rate of \$2.00/sheet.

Regarding prescription and paperwork requests:

- *Please allow at least 24 hours for a prescription refill request to be phoned to the pharmacy or printed for pick up in the office.
- *Five (5) business days should be allowed for all paperwork requests from places of employment (disability papers, etc.).

Regarding cell phone use and food/drink:

- *Cell phones must be turned to 'silent' or 'off' upon entering the examination room. If used while in the front waiting room, we kindly ask that you keep your conversation brief and at a quiet tone out of respect for other patients and staff.
- *Food and drink must not be taken into the examination room – this is against the federal OSHA policy. Food and drink may be left in the front waiting room or you may ask the staff to dispose of the item(s) for you.

Please sign below to acknowledge that you have read and understand the Office Policies of Family Foot Health center and have had any questions answered you may have regarding the policies.

Patient signature/Authorized Signature (and relationship)

Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in my treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given the right to review the Notice of Privacy Practices, found in the waiting room, prior to signing this acknowledgment. I understand that I may ask for a copy of these Privacy Practices. I understand that Family Foot Health Center reserves the right to change these policies at any time and I may contact this office for an updated copy at any time.

I understand that I may request in writing that Family Foot Health Center restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that if I request my information be withheld from an insurance company, and this withholding affects payment from that company, I will be responsible for payment in full to Family Foot Health Center.

PRINTED Name of Patient/Guardian

Signature of Patient/Guardian

Date