

NEW PATIENT REGISTRATION FORM

Today's Date _____ Social Security # _____ Email _____

Last Name _____ First Name _____ MI _____

Nickname/Maiden Name _____

Address _____ Apt/Unit# _____

City _____ State _____ Zip _____

Home Phone _____ Work phone _____ Cell Phone _____

Age _____ Date of Birth _____ Martial Status _____ Gender _____

Race: **Optional** Black _____ White _____ Asian _____ Hispanic _____ American Indian _____ Other _____

Employer _____ Occupation _____

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

EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

INSURANCE INFORMATION

Primary Insurance Company Name _____ Phone # _____

Insurance Company Address _____

Insurance Company City _____ State _____ Zip Code _____

Insured Name (if other than self) _____ Relationship _____

Social Security # _____ Date of Birth _____

Policy/Member # _____ Group # _____

Employer Providing Insurance _____

Secondary Insurance Company Name _____ Phone # _____

Insurance Company Address _____

Insurance Company City _____ State _____ Zip Code _____

Insured Name (if other than self) _____ Relationship _____

Social Security # _____ Date of Birth _____

Policy/Member # _____ Group # _____

Employer Providing Insurance _____

Primary Care Physician

Pharmacy

Name _____ Name _____

Address _____ Address _____

Phone# _____ Phone# _____

Medical Information

Height _____ Weight _____ Shoe Size _____

Tobacco use _____ Alcohol use _____

The reason for your visit today _____

CURRENT MEDICATIONS

SURGICAL HISTORY

ALLERGIES

- Advil
- Aspirin
- Codeine
- Demerol
- Feldene
- Iodine
- Other: _____
- _____
- Mercurial
- Motrin
- Novocain
- Penicillin
- Sulfa
- Tape
- I have no known allergies

MEDICAL FAMILY HISTORY

Please indicate **Y** for yes. **N** for no, **Patient** for the patient history and **Family** for family history.

	Patient	Family		Patient	Family		Patient	Family
AIDS/HIV			Diabetes			High Blood Pressure		
Anemia			Dizzy Spells			Kidney Problems		
Arthritis			Epilepsy			Nervous Problems		
Asthma			Fainting			Numbness in Feet		
Bleeding Disorders			Foot or Leg Cramps			Tuberculosis		
Burning in Feet			Gastro-intestinal Disorders			Tumors (please list below)		
Cancer			Glaucoma			Ulcers		
Chest Pain			Gout			Varicose Veins		
Circulatory Problems			Heart Disease			Other		
Cold Feeling In Feet (Continually)			Hepatitis or Jaundice					

NOTICE OF PRIVACY

I ACKNOWLEDGE 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 _____

PHI 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.

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 _____

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 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.

RESPONSIBLE PARTY – Adult present signing consent to treat

Patient Relationship to Responsible Party _____

Last Name _____ First Name _____ MI _____

Social Security# _____ Date of Birth _____

Address _____ Apt/Unit# _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Other _____

FINANCIAL POLICY

Date: _____

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 that:

- 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.**

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:

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 service are covered benefit 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 Date _____

Responsible Part Signature (if other than patient)

