

Family Foot and Ankle Centers Patient Registration Form

(Please present your insurance cards to the receptionist upon arrival)

Patient's Name _____
First Last M.I. Nickname

Address _____ # _____

City _____ State _____ Zip code _____

Phone: Home _____ Cell _____

Work _____ Email _____ @ _____

SS# _____ - _____ - _____ Date of Birth ____/____/____ Gender ___ Male ___ Female

Marital Status _____ How did you hear about us? _____

Primary Care Physician _____ Date Last Seen by PCP _____
Name, Address & Phone Number

Responsible Party Name _____ Relationship _____
First Last M.I.

Responsible party: Date of Birth ____/____/____ SS# _____ - _____ - _____ Gender ___ Male ___ Female

Primary Insurance Information Insurance Name _____

Policy Holder Name _____ DOB ____/____/____

Insurance ID # _____ Group # _____ Relationship to Holder _____

Secondary Insurance Information Insurance Name _____

Policy Holder Name _____ DOB ____/____/____

Insurance ID # _____ Group # _____ Relationship to Holder _____

Primary Language: _____

Ethnicity: ___ Hispanic or Latino ___ Not Hispanic or Latino

Race: ___ American Indian or Alaskan Native ___ Asian ___ Black or African American
___ Native Hawaiian or other Pacific Islander ___ White

Preferred Pharmacy: _____
(Pharmacy Name, Address & Phone Number **REQUIRED!**)

Emergency Contact _____ Phone _____ Relationship _____

I understand and acknowledge that I am personally responsible for the services rendered at this facility. Family Foot and Ankle Centers will bill my insurance carrier as a courtesy. In the event of non-payment, I understand I will be responsible for any outstanding balances.

X _____ Date _____
Patient Signature or Guardian for the Minor Patient

Financial Policy of Family Foot and Ankle Centers, PLLC

Payment in full is due at time of service unless prior arrangements have been made.
Office Visit co-payments for participating HMO/PPO insurances are due at the time of service.

HMO/PPO claim denials due to no referral or authorization are the patient's responsibility. Office staff will notify and assist you in referral/pre-certification procedures, but final responsibility lies with the patient to comply with their specific insurance's requirements. All referrals must be presented to our business office before seeing the doctor.

Please present your insurance card each time you visit if we participate with your plan to insure proper filing information to submit claims. Otherwise, your visit may not be covered and you will be responsible for payment.

The following services cannot be billed to insurance and will be the patients' responsibility.

- \$10.00 fee for any prescription that must have pre-authorization phone call. (Fax forms are free.)
- \$50.00 charge for insurance based Peer to Peer consultations.
- \$50.00-\$100.00 charge for any disability forms.
- \$400.00 per hour prorated charge for any lawyer letters.
- \$50.00 charge for all returned checks.

Patients will be sent one statement for any outstanding co-payments and unpaid balances due after insurance claims processing.

Consider keeping a credit card on file under our secured merchant services option.

See attached Credit Card On File Agreement.

Please be on time for your appointment. If you need to reschedule your appointment, we require a minimum of 24 hours notice. If you missed the scheduled appointment without notifying our office a \$50.00 charge will be added to your account.

If your account must be forwarded to a collection service and/or an attorney because of non-payment, you will be responsible **for all collection fees** and/or attorney fees charged by these services.

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Family Foot and Ankle Center all insurance benefits, payable to me for services rendered. I understand that I am responsible for all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, any third party as it materially relates to services provided, or requested by physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

By my signature I acknowledge receipt of a copy of this policy and hereby agree to its terms.

Signature: _____

Printed Name: _____ Date: ____/____/____



CREDIT CARD ON FILE AGREEMENT

PATIENT'S NAME: _____ **DOB:** ___/___/___

Patient Email: _____

Cell number for text notifications: _____

FFAAC has implemented a new billing policy with our Merchant services. We can now securely save your credit or debit card on file to cover any balance due after your insurance benefits are applied. Once your credit card information is entered it is encrypted and cannot be viewed or accessed by any other organizations. Our merchant services are independently audited and certified at the highest levels. This policy will simplify how you pay your medical bills.

I agree to keep my credit card information saved on file with Family Foot and Ankle Centers.
Changes to this form by the patient are not valid unless signed off by the office.

My card can be used for any outstanding balances due after insurance claims are processed.

You will receive a statement in the mail to inform you of the balance due on your account. You will need to contact FFAAC within 10 days of the statement date to change the payment method or your saved card will be run.

You will receive a receipt via email for any charges posted on your saved credit card.

Last 4 digits on the card _____ **Card type-** Debit CC HSA/FSA

Cardholder Signature: _____ **Date:** ___/___/___

Family Foot and Ankle Centers

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

Please Answer All of the Questions: **Shoe size:** _____ **Shoe type:** _____

Chief Complaint: _____

How is your general health? ___ Excellent ___ Good ___ Poor **Height** _____ **Weight** _____

Please check all that apply:

- | | | |
|-----------------------|--------------------------|---------------------|
| ___ Diabetes | ___ Anxiety / Depression | ___ Fibromyalgia |
| ___ Stroke | ___ Cholesterol | ___ Thyroid |
| ___ Leg Cramps | ___ Asthma | ___ Gout |
| ___ Epilepsy | ___ High Blood Pressure | ___ Stomach Ulcer |
| ___ Tumors | ___ Tuberculosis | ___ Polio |
| ___ Bleeding Problems | ___ Kidney Trouble | ___ Heart Trouble |
| ___ Glaucoma | ___ Arthritis | ___ Anemia |
| ___ HIV | ___ Varicose Veins | ___ Circulation |
| | ___ Cancer | ___ Fainting Spells |
| | ___ Blood Clots | |

Other Previous Illnesses: _____

Previous Operations or Hospitalizations: _____

Previous Injuries: _____

Family Medical Problems: (please list problems by family member i.e. mother, father, sister, brother, etc.)

Member: _____ Problem(s) _____

Member: _____ Problem(s) _____

Member: _____ Problem(s) _____

What Medications are you taking? (Please include prescription, over-the-counter, and herbal supplements)

Do you have any allergies? ___ YES or ___ NO *If Yes Please select from the following:*

- | | | |
|---------------|-----------------|--------------------|
| ___ Aspirin | ___ Mercurials | ___ Nylon/Plastic |
| ___ Novocaine | ___ Merthiolate | ___ Antihistamines |
| ___ Codeine | ___ Iodine | ___ Penicillin |
| ___ Demerol | ___ Adhesive | ___ Sulfa |
| ___ Latex | Other: _____ | |

Reaction: _____

Smoking Status: ___ Current Every Day Smoker ___ Current Some Day Smoker
 ___ Former Smoker ___ Never Smoker

Are you a Tobacco User ___ Yes ___ No

PATIENT CONSENT FORM

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

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

You have informed me of your *Notice of Privacy Practices* containing a more complete description of the users. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at the time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: ____/____/____

AUTHORIZATION TO RELEASE INFORMATION TO:

1) _____

2) _____