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 _____
Name, Address & Phone Number

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

Responsible Party: Date of Birth _____/_____/_____ **SS#** _____-_____-_____ **Gender** ___ Male ___ Female

Address: _____ **Phone** _____

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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 _____

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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

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

Emergency Contact _____ **Phone** _____**Relationship**_____

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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 options.
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 you miss or cancel your surgery with less than 48 hours notice, a $100 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: _____/_____/_____

FAMILY
Foot and Ankle
Center

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 <u>any outstanding balances</u> 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 □ HAS/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: _____

Date of last visit to Primary Care Physician: _____

How is your general health? _____Excellent ____Good ____Poor **Height**_____ **Weight**_____

Please check all that apply:

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

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
___ Novocaine
___ Codeine
___ Demerol
___ Latex
___ Mercurials
___ Merthiolate
___ Iodine
___Adhesive
Other: _____
___ Nylon/Plastic
___ Antihistamines
___ Penicillin
___ Sulfa

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 form 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)_____