Advanced Foot & Ankle Specialists

PATIENT INFORMATION

DATE_____PHARMACY/LOCATION_____PCP_____

PATIENT NAME_____SEX_____AGE_____ DATE OF BIRTH_____/_____/_____

ADDRESS_____HOME PHONE_____

CITY/STATE_____ZIP_____

E-MAIL ADDRESS_____MOBILE PHONE_____

RACE_____ETHNICITY_____PRIMARY LANGUAGE_____MARITAL STATUS: _____

PATIENT'S EMPLOYER NAME & ADDRESS_____

OCCUPATION_____BUSINESS PHONE_____

IN CASE OF AN EMERGENCY WHOM MAY WE CONTACT_____

PHONE_____RELATIONSHIP_____

HOW WERE YOU REFERRED TO OUR OFFICE_____

WHO IS THE RESPONSIBLE PARTY (IF THE PATIENT IS A MINOR OR STUDENT**)** _____

ADDRESS_____

SUBSCRIBER (INSURANCE HOLDER'S) NAME_____DOB_____/_____/_____

INSURED'S EMPLOYER NAME & ADDRESS_____

PHONE NUMBER_____RELATIONSHIP TO PATIENT_____

IS THIS VISIT DUE TO A WORK-RELATED INJURY? YES NO

WORKERS COMP. CARRIER NAME_____

DOES YOUR INSURANCE REQUIRE PRIOR AUTHORIZATION/REFERRAL YES NO
(I understand that I am financially liable for all costs incurred for all visits if my insurance requires a referral and I fail to obtain one.)

PLEASE READ CAREFULLY AND SIGN:

SIGNATURE ON FILE

I request that payment of authorized benefits be made either to me or on my behalf to Advanced Foot and Ankle Specialists for any services furnished to me by that physician / supplier. I authorize any holder of medical information about me to release to CMS and its agents, or any other supplier of medical benefits, any information needed to determine those benefits, or the benefits for related services.

I understand that regardless of any insurance coverage that I may have, it is my responsibility to pay my bill. I understand that I am responsible for my bill if my insurance does not pay because I failed to obtain a referral if one was required. I further understand that my insurance is designed to reimburse Advanced Foot and Ankle Specialists for covered expenses. I understand further that not all services are covered by Medicare or other insurance plans and acknowledge that I am responsible and will pay for those services. I agree to pay all costs of collection, including a reasonable attorney's fee, incurred in the collection of any amounts not paid, as required above.

_____

(PATIENT OR RESPONSIBLE PARTY)

Advanced Foot & Ankle Specialists

Patient Name: _____ **Patient DOB:** _____

Review of Systems — Check the conditions/diseases you have now or have had in the past:

__Abnormal ECG
__Alcoholism
__Allergies
__Anemia
__Anxiety
__Asthma
__bleeding Disorder
__bronchitis (frequent)
__CAD
__Cancer
__Cerebral Palsy
__CHF
__Cirrhosis
__Clotting Disorder
__COPD
__Deep Vein Thrombosis
__Diabetes Mellitus Type 1 or Type 2
__Diverticulitis
__Epilepsy
__Gestation Diabetes
__Gout
__Hepatitis A B C
__High Blood Pressure
__High Cholesterol
__HIV disease/risk
__Hypertension
__Keloid
__Kidney Disease
__Leg Swelling
__Liver Disease
__Lower Extremity Swelling
__Lyme Disease
__Myocardial Infarction
__Osteoporosis
__MS
__Pacemaker Hx
__Psoriasis
__Psychiatric Disorder
__Rheumatoid Arthritis
__Seizures
__Sickle Cell Anemia
__Skin Ulcer
__Stomach Ulcer
__Stroke
__Substance Abuse
__Tuberculosis
__Other_____

List your medications: _____

_____

List your allergies to medications or substances: _____

_____

MEDICAL AND SOCIAL HISTORY

Have you ever had surgery? Yes No If Yes, what kind and when? _____

_____

_____

Did you have any complications related to your surgery? Yes No If Yes, describe: _____

_____

Circle all that apply:

Tobacco use? Cigarettes Cigars Smokeless/Chewing tobacco If so, how much? _____

Alcohol use? Current Previous Drinks per day? _____ What kind? _____ Last used? _____

Illegal drug use? Injection Oral Smoking What kind? _____ Last used? _____

Last day of Work (If Applicable) _____

FAMILY HISTORY

Circle all of the diseases and conditions below that run in your family:

Heart disease Rheumatoid Arthritis Bleeding Disorders Cancer Diabetes Other_____

Bleeding Disorders Connective Tissue Disorders Muscular Dystrophy Hypertension Other_____

Patient Name: _____ **Patient Signature:**_____ **Date:** _____

TO BE COMPLETED BY DOCTOR

☐ All systems reviewed and negative.
☐ All systems reviewed with the following findings:
_____

Doctor's signature: _____

Date of visit: _____

Advanced Foot & Ankle Specialists

CREDIT CARD ON FILE POLICY

At Advanced Foot and Ankle Specialists, we require your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are responsible.

Without this authorization, a billing fee of $10.00 will be added to your account for any balances that we must attempt to collect through mailing a monthly statement. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will be charged for each month that the bill remains unpaid.

Please be advised that this card will be charged $50.00 in the event of a "no show" (cancellation within 24 hours of an apt is considered a "no show").

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

Any outstanding balance over 90 days, with no attempt to make a payment, will be charged to the card listed below.

I authorize Advanced Foot and Ankle Specialists to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Amex ☐ Visa ☐ Mastercard ☐ Discover

Credit Card Number _____

Expiration Date _____ / _____ / _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State_____ Zip _____

I (we), the undersigned, authorize and request Advanced Foot and Ankle Specialists to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Advanced Foot and Ankle Specialists.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Advanced Foot and Ankle Specialists in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____