Foot & Ankle
Center of Arizona

7312 East Deer Valley Road, Suite 110
Scottsdale, Arizona 85255

480.342.9999
www.arizonafoot.com

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____/_____/_____
First Middle Last

PHONE: Best #: _____ Alternate #: _____

HOME ADDRESS:_____
Street City State Zip

BILLING ADDRESS (if different): _____
Street City State Zip

E-MAIL ADDRESS: _____ Sex: M ☐ F ☐

BEST WAY TO CONTACT YOU: _____

MARITAL STATUS_____ SOCIAL SECURITY # (optional): _____

REFERRING DOCTOR: _____

OTHER REFERRING SOURCE: ☐ Ads ☐ Family/Friends ☐ Insurance ☐ Newspaper ☐ Internet ☐ Other

PHARMACY: _____
Name Cross streets Phone

PATIENT EMPLOYER INFORMATION

PATIENT'S EMPLOYER NAME: _____
PATIENT'S OCCUPATION: _____CONTACT PHONE: (___)_____

1. If today's visit is due to an injury at work, please check: ☐ (Please complete accident form)
2. Have you notified your personnel department? ☐ Yes ☐ No
3. Please give a brief description of the injury: _____

_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____ POLICY #: _____
POLICYHOLDER'S NAME: _____ DOB: _____
ADDRESS: (If different from patient): _____
RELATIONSHIP TO PATIENT: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP_____ PHONE: _____

EXPLANATION OF PAYMENT POLICY & INSURANCE FILING PROCEDURES

I hereby authorize Foot & Ankle Center of Arizona to release medical information and necessary data pertinent to the filing of insurance papers in the interest of the patient named above and the facility. I authorize my insurance carriers to pay benefits directly to Foot & Ankle Center of Arizona on any unpaid services filed on my behalf by Foot & Ankle Center of Arizona. I understand that I am responsible for payment to Foot & Ankle Center of Arizona for charges for the above patient, regardless of my insurance coverage. I also understand that Foot & Ankle Center of Arizona is not ultimately responsible for collecting my insurance or negotiating settlements of claims.

Patient's Signature: _____ *Date:* _____

Please fill out the following confidential form for our records

PATIENT NAME: _____ AGE:_____ HEIGHT _____ WEIGHT _____ SHOE SIZE _____
CURRENT FOOT OR ANKLE PROBLEM: _____
_____
WHEN DID THE PROBLEM START: _____
WHAT HAS BEEN DONE TO TREAT THE PROBLEM? _____
_____
ARE YOU NOW OR HAVE YOU BEEN UNDER A PHYSICIAN'S CARE IN THE PAST TWO YEARS? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN: _____
NAME OF PRIMARY PHYSICIAN: _____ PHONE: _____
NAME OF FORMER PODIATRIST/ORTHOPEDIST: _____
WHAT CONDITIONS WERE YOU TREATED FOR: _____

MEDICAL HISTORY

☐	DIABETES	☐	KIDNEY OR BLADDER
	☐ TYPE I		TYPE:
	☐ TYPE II	☐	FOOT PROBLEMS
☐	THYROID DISEASE	☐	HIGH BLOOD PRESSURE
	☐ HYPOTHYROIDISM	☐	HIGH CHOLESTEROL
	☐ HYPERTHYROIDISM	☐	BLEEDING DISORDERS (SICKLE CELL)
	☐ OTHER:	☐	CANCER
☐	RHEUMATIC FEVER		TYPE:
☐	VASCULAR/CIRCULATORY DISEASE	☐	ANEMIA/BLOOD DISEASE
	TYPE:	☐	ASTHMA
☐	HEART DISEASE	☐	BRONCHITIS
☐	STROKE	☐	ACID REFLUX
☐	HEART ATTACK	☐	STOMACH ULCER
☐	GOUT	☐	EPILEPSY/SEIZURES
☐	LIVER DISEASE	☐	DEPRESSION
☐	ACCIDENT/INJURIES	☐	ANXIETY
☐	ARTHRITIS	☐	OTHER:
☐	IMMUNE DISEASE (HIV, AIDS)		

MEDICATIONS (Please include dosage and frequency of each)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7 _____
8. _____
9. _____
10. _____

ALLERGIES (Penicillin, Novocaine, Tape, etc.)

1. _____
2. _____
3. _____
4. _____

SURGERIES & HOSPITALIZATIONS (Describe procedure, year, any complications)

1. _____
2. _____
3. _____
4. _____
5. _____

SOCIAL HISTORY

OCCUPATION: _____

TOBACCO: ☐ YES ☐ NO IF YES, HOW MUCH? _____ ALCOHOL: ☐ YES ☐ NO IF YES, # OF DRINKS DAILY ____

ILLICIT DRUGS: ☐ YES ☐ NO IF YES, HOW MUCH? _____

FAMILY HISTORY

	MOTHER ☐ Living ☐ Deceased	**FATHER** ☐ Living ☐ Deceased
Diabetes		
High blood pressure		
Heart disease		
Stroke		
Mental Illness		
Cancer		
Gout		
Foot problems		
Other		

CONSENT FOR RELEASE OF INFORMATION/RECORDS TO YOUR PRIMARY OR REFERRING DOCTOR

DATE ____/____/___ PATIENT'S NAME: _____
(First) (Last)

SOCIAL SECURITY #: ____-____-____

I HEREBY GIVE MY PERMISSION FOR FOOT & ANKLE CENTER OF ARIZONA TO RELEASE OR DISCLOSE TO:

_____
(Name of Doctor, Hospital, Agency, etc.)

THIS CONSENT IS SUBJECT TO REVOCATION AT ANY TIME IN THE FORM OF WRITTEN NOTICE FROM ME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON, OR WITHOUT REVOCATION, WILL EXPIRE ON ____/____/____ (THIS IS NOT TO EXCEED ONE YEAR).

SIGNATURE OF PATIENT: _____ DATE: ____/____/____

BESIDES THE PERSON LISTED AS MY EMERGENCY CONTACT, I AUTHORIZE THE FOLLOWING ADDITIONAL PEOPLE WHO MAY RECEIVE MY PROTECTED HEALTH INFORMATION. I UNDERSTAND I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY GIVING WRITTEN NOTIFICATION TO THIS OFFICE.

THESE PEOPLE MAY RECEIVE MY PROTECTED HEALTH INFORMATION:

NAME: _____ DATE OF BIRTH: ____/____/____

RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ CHILD ☐ PARENT ☐ OTHER

NAME: _____ DATE OF BIRTH: ____/____/____

RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ CHILD ☐ PARENT ☐ OTHER

MAY WE LEAVE MESSAGES REGARDING OFFICE AND TESTING APPOINTMENTS ON YOUR ANSWERING MACHINE?

☐ YES ☐ NO

SIGNATURE: _____ DATE: ____/____/____

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY WHICH IS LOCATED ON THE OFFICE WEBSITE, AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOOSE) AND UNDERSTAND THE NOTICE.

_____ _____

PARENT OR AUTHORIZED SIGNATURE DATE

_____

PRINT NAME

PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank your for choosing the Foot & Ankle Center of Arizona for your care. This financial policy is an important part of your care. Due to increased insurance company demands, we ask you to read and agree to the following provisions:

REFERRALS – If your insurance plan requires a referral from your primary care physician, it is **your** responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not obtain your referral, you will be responsible for the visit charges in full at the time of service.

APPOINTMENTS – As a courtesy, we attempt to contact every patient to remind them of their appointment. We kindly ask you to notify us 24 hours in advance in the event you cannot keep your appointment. A $50 fee will be incurred by you in the event of a NO-SHOW or a cancellation made less than 24 hours before your appointment time.

INSURANCE – Your insurance policy is a contract between you and the insurance company. As a courtesy, we will file your insurance claim for you. This allows the insurance company to pay the doctor's office directly.

CO-PAYMENTS & DEDUCTIBLES – Our policy is to collect your portion of the insurance designated co-payment/co-insurance/deductible payments at the time of service. Please be prepared to pay at your visit. We accept VISA, MASTERCARD, AMEX, DISCOVER, CASH, OR CHECK.

OUT OF NETWORK BENEFITS – If we do not participate with your plan but you would like to be treated in our office, we will send a courtesy bill to that carrier on your behalf. Patients are responsible for co-pays, co-insurance and deductibles at the time of the service. A paid receipt will be provided to you to submit to your insurance company. Should your insurance not pay the claim, you will be responsible with the full amount due. If you receive a payment from the insurance company directly, please forward it to our office if you have an outstanding balance.

SERVICES NOT COVERED BY YOUR INSURANCE PLAN – Services not covered by your insurance plan are your responsibility and are to be paid in full at the time services are provided.

PRIVATE PAY PATIENT – If you have no insurance coverage, full payment is expected at the time of service.

SURGERY PATIENTS – Surgical procedures might require a pre-payment of deductible and co-insurance payments if applicable. You will be informed if this applies to your surgery. Surgery Date Change/Cancellation Fee is $250.00 after your surgical consultation.

DELINQUENT ACCOUNTS – Statements are mailed out on a monthly basis. We request that your balance is paid off within 30 days. Past due accounts are subject to collection proceedings without further notice if unpaid after 90 days. In the event your account is turned over to collections, you are responsible for all associated collection costs and late fees.

RETURNED CHECKS – Returned checks are subject to a $25.00 fee and all future payments need to be made by cash or a valid credit/debit card.

LABORATORY FEE – Laboratories bill separately for their services. Any Lab services that are not covered by your insurance will be your responsibility.

ADDRESS AND INSURANCE CHANGES – Please let us know if you have changes in your address, phone numbers, insurance, etc. so that your information is always current in our records.

AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR - Patients under the age of 18 (minors) must be accompanied by a parent/legal guardian unless prior arrangements have been made. In the event that the accompanying adult is not the parent/legal guardian, Consent to Treat Form must be filled out. This can be found on our website. The person bringing in the child for medical treatment will be held responsible for payment at the time services are rendered.

DIVORCE/CUSTODY - Our policy is to hold the parent who brings in the child for medical treatment responsible for payment at the time of service. Our office does require documentation from the court for all legal matters that relate to your child's care; *i.e.*, custody, medical decisions, medical record access, etc.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY AND I AGREE TO THE TERMS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED IN THE EVENT MY INSURANCE DENIES PAYMENT AFTER A CLAIM HAS BEEN SUBMITTED BY FOOT & ANKLE CENTER OF ARIZONA. I UNDERSTAND THAT MY INSURANCE IS AN ARRANGEMENT BETWEEN MYSELF AND MY INSURANCE COMPANY, AND THAT IT IS MY RESPONSIBILITY TO UNDERSTAND MY BENEFITS.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY:

_____