7312 East Deer Valley Road Suite 110 Scottsdale, Arizona 85255

480-342-9999 **www.arizonafoot.com**

Patient Acct. # Chart

PATIENT INFORMATION

Name:____ Date of Birth _____/_____/_____
First Middle Last

Work phone: (___)_______________________Ext.______ FAX: (___)_____________________________
Home phone: (___)_______________________ Cell phone: (___)_____________________
Home address:____
Street City State ZIP

E-mail address:______________________________ Sex: M F Marital Status____________________
Social Security #______________________________
Referring Doctor:______________________________Pharmacy Name:______________Cross Streets___________
Other referring source: Advertisement Family/friend Insurance Newspaper/mail Internet/website Other______

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:____
Group name:___________________________ Effective Date:_____________________________________
Patient's Relationship to Policyholder:____

EMERGENCY CONTACT INFORMATION
Name:___________________________Address:____
Home phone:(____)______________Work phone: (____)______________Cell 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:________________________

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PATIENT HISTORY FORM

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
☐ Thyroid disease
☐ Rheumatic fever
☐ Vascular/Circulatory Disease
☐ Heart disease
☐ Stroke or heart attack
☐ Gout
☐ Liver disease
☐ Accident/injuries
☐ Arthritis
☐ Kidney or bladder
☐ Immune disease (HIV, AIDS)
☐ Foot problems
☐ High blood pressure
☐ Bleeding disorders (sickle cell)
☐ Cancer
☐ Anemia/blood
☐ Asthma/bronchitis
☐ Other__________
☐ Stomach ulcer/reflux
☐ Epilepsy/seizures
☐ Depression or anxiety

Please explain any positive responses from above information:_________________________________
____

MEDICATIONS (please include dosage of each)
1. ____________________________________5. ____
2. ____________________________________6. ____
3. ____________________________________7. ____
4. ____________________________________8. ____

ALLERGIES: (penicillin, novocaine, tape, foods, etc.)
1. ____
2. ____

SURGERIES & HOSPITALIZATIONS (describe procedure, year, any complications)
1. ____________________________________5. ____
2. ____________________________________6. ____
3. ____________________________________7. ____
4. ____________________________________8. ____

SOCIAL HISTORY
Occupation:__________________________________ Tobacco: If yes, how much?_________________
Alcohol: _______If yes, # of drinks daily__________ Illicit drugs: If yes, how much?_______________
FAMILY HISTORY (diabetes, heart disease, gout, cancer, foot problems or other): __________________
Whom may we thank for referring you to our office?____

I hereby give Foot & Ankle Center of Arizona permission to diagnose and administer treatment for my foot condition and authorize any release of information obtained in the course of my treatment.
Signature____

Financial Policy

As our patient, you are responsible for all authorizations/referrals needed to obtain treatment in this office. Unless other arrangements have been made in advance by you or your health insurance carrier, payment for office services are due at the time of service. We accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, cash, or check.

- $25.00 fee for any forms which requires completion by the doctor such as short term disability (STD), family medical leave (FMLA), etc. Please allow 5-7 business days for completion.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. This allows the insurance company to pay the doctor directly.
- If your insurance company does not pay the doctor within a reasonable period, we will hold you responsible for payment of the services.
- We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do *not* have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- For most services provided in the hospital, we will bill your insurance health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures that require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due to this office.
- There is a fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- We require a 24 hour notice for cancellation of appointments.
- If you have any questions about our financial policy please discuss them with our front office staff or the Office Manager.

Signature of Patient/Responsible Party:____

Printed Name of Patient/Responsible Party:____

Consent for Release of Information/Records
To your Primary or Referring Doctor

Date ___/___/____ Patient's Name____
(First) (Last)

Date of Birth _____________________

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 ___/___/____

Acknowledgement of receipt of notice of privacy practices

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.

____
Print Name Date

____
Parent or Authorized Signature

I authorize the following people who may receive my Protected Health Information. I understand that 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

Signed:____ Date: :___/___/___