FOOT & ANKLE SPECIALISTS

PATIENT INFORMATION

First Name: _____ Last **Name:** _____ **MI:** ____

Name of Guardian (if patient is under 18 years of age): _____

Relation: ☐Parent ☐Grandparent ☐Sibling ☐Legal Guardian ☐Other: _____

Date of Birth: _____ **Age:** _____ **Social Security Number:** _____ Gender: ☐ Male ☐ Female

Marital Status: _____ **Primary Language Spoken:** _____

Race: (Please Select)

☐White
☐Hispanic
☐Asian
☐Other
☐American Indian or Alaska Native
☐Black or African American
☐Native Hawaiian or Pacific Islander
☐Decline

Ethnicity: (please select one)

☐Hispanic or Latino
☐Not Hispanic or Latino
☐Decline

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email: _____

Emergency Contact: _____ **Relation:** _____ **Phone:** _____

PHARMACY/PRIMARY CARE DOCTOR INFORMATION

Pharmacy: _____ Location: _____ #: _____
City / Zip

Primary Care Physician: _____ Phone #: _____

How did you hear about us? _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Policy ID #: _____

Group #: _____ Policy Holder Name: _____ DOB: _____

Relationship to patient: ☐Self ☐Spouse ☐Child ☐Other: _____ Copay Amount: $_____

Secondary Insurance Company: _____ Policy ID #: _____

Group #: _____ Policy Holder Name: _____ DOB: _____

Relationship to patient: ☐Self ☐Spouse ☐Child ☐Other: _____ Copay Amount: $_____

Patient/Guarantor Signature: _____ ***Date:*** _____

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PATIENT MEDICAL HISTORY

Reason for your visit today: _____

When did the problem begin: _____

Have you had any previous treatment? ☐No ☐Yes, Treated by: _____

Check all treatments received for this condition:

☐Pain Medication	☐Physical Therapy	☐Bone Scan	☐CT Scan
☐Injection	☐Antibiotics	☐Ice/Stretching	☐Hospitalization
☐X-Rays	☐Surgery	☐MRI	☐Other: _____

Weight: _____ **Height:** _____ **Shoe Size:** _____

Have you been diagnosed with any of the following (Mark all the ones that apply)? ☐NONE

☐Anemia	☐Emphysema	☐HIV+/Aids	☐Liver Disease (hepatitis)
☐Arthritis	☐Fibromyalgia	☐Heart Disease	☐Stomach Ulcers/Reflux
☐Back problems	☐Glaucoma	☐High Cholesterol	☐Stroke
☐Blood Clots	☐Gout	☐Irregular Heart Beat	☐Thyroid Disorder
☐Depression	☐Heart Attack	☐Kidney Stones	☐Tuberculosis
☐Diabetes	☐High Blood Pressure	☐Kidney Disease	☐Other: _____

Do you smoke or chew tobacco? ☐No ☐Yes, how often/how many? _____

Do you drink alcohol? ☐No ☐Yes, how often? _____

Current Medications: _____

_____

_____

Allergies/Reactions: _____

_____

Previous Surgeries (please list any complications if applicable): _____

_____

_____

_____

Patient/Guarantor Signature: _____ ***Date:*** _____

FOOT & ANKLE SPECIALISTS

FINANCIAL POLICY & AGREEMENT

PAYMENTS FOR SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED: We accept cash, personal checks, Mastercard, Visa, American Express, and Discover. Returned checks are subject to a service charge of $30.00 or 5% whichever amount is greater, and you will lose the privilege to write checks in our office.

MEDICARE: We will bill your insurance(s) for you. After the insurance processes your claim, you (the patient or guarantor) agree to pay the deductible and/or 20% of the allowable charges, if applicable.

COMMERCIAL INSURANCE: Copays are due at the time of check-in. We will bill your insurance(s) for you. After the insurance processes your claim, you agree to pay your patient responsibility.

HMO INSURANCE: It is your responsibility to: obtain a referral from your primary care physician prior to your appointment, and also to check with your insurance to obtain your insurance benefits.

WORKERS COMPENSATION: It is your responsibility to call your employer to get the visit authorized. In the event that you fail to prosecute the claim for Worker's Compensation for this injury or the condition is determined not the result of a compensable Worker's Compensation case, you agree to pay the usual and customary fee for services rendered to you in this case.

CHILDREN OF DIVORCED PARENTS: PAYMENT IS DUE AT THE TIME OF SERVICE regardless of who is responsible by order of the divorce degree.

FINANCIAL AGREEMENT: We are happy to discuss your proposed treatment and do our best to answer any questions relating to your insurance. In order to do so, please be aware of the following:

- **Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.** To enable our office to file your insurance, you must provide accurate information at each visit.
- **Not all services are a covered benefit. Some insurance companies arbitrarily select certain services they will not cover (i.e., x-rays, labs, durable medical equipment {DME}, elective procedures, and pre-existing conditions.)**
- **Due to timely filing limits for insurance companies, you must present your current insurance card at the time of check-in. If you do not have your insurance card, you may: call our office the same day as your visit, reschedule your appointment, or pay out of pocket for your visit.**

I hereby assign Foot & Ankle Specialists of Utah all payments for medical services rendered to myself or dependent. I understand that I am responsible for any amount not covered by my insurance. I hereby understand that if I do not have active insurance coverage, that I am being accepted by Foot & Ankle Specialists of Utah as a Self-Pay patient and am held financially responsible for all services rendered.

COLLECTIONS: We must emphasize that as your medical care providers, our relationship and concern is with you and your health-not the insurance company. ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED. If your account is 90 days old and unpaid, including those that your insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such cases occur, please contact us promptly for assistance in the management of your account. If your account is sent to collections for unpaid balances, you agree to pay all reasonable costs of collection, including collection fees, whether a suit is filed or not.

By signing below, I recognize that I have read and understand the office financial policy.

Patient/Guarantor Signature: _____ ***Date:*** _____

FOOT & ANKLE SPECIALISTS

AUTHORIZATION TO TREAT / ACKNOWLEDGMENT OF RECEIPT OF HIPPA PRIVACY NOTICE

AUTHORIZATION TO TREAT:
I hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures / tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I hereby authorize Foot & Ankle Specialists of Utah to furnish information to insurance carriers concerning my illness and treatment.

ACKNOWLEDGMENT OF RECEIPT OF HIPPA PRIVACY NOTICE:
In accordance with HIPPA, I have had the opportunity to read and receive a copy of the Privacy Practices located in the office of Foot & Ankle Specialists of Utah. I understand my information will be used for the purpose of treatment, payment, and healthcare operations.

NOTE: Original x-rays are the property of this office. Copies may be purchased for $5.00 each.

A photocopy of this consent shall be considered as valid as the original.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient/Guarantor Signature: _____ ***Date:*** _____