ADVANCED
Foot and Ankle

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PATIENT REGISTRATION FORM **TODAY'S DATE: _____**

Last Name:	First:	M.I.
Address:		
City:	State:	Zip:
Phone: ( )	Mobile: ( )	
SSN:	DOB:	Age:
Occupation Status:	Marital Status:	Sex: M F
How did you hear about us?		
Email:		

EMERGENCY CONTACT:

Name:	Relation:	Phone:

INSURANCE INFORMATION: *(Provide copy of insurance cards & photo ID)*

Primary:	Plan ID:
Subscriber:	Date of Birth:
Secondary:	Plan ID:
Subscriber:	Date of Birth:

GUARANTOR/BILLING INFORMATION:

Last Name:	First:	DOB:
Address:	Relation:	Phone:

EMPLOYER:

Name:	Phone:
Address:	

PRIMARY CARE/FAMILY DOCTOR:

Primary Care Doctor:	Last Seen:
Location:	Phone:

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HIPAA AUTHORIZATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) states that the Practice cannot share your protected health information (PHI) without your permission, except in certain situations. For example, your PHI can be shared without your permission if it is used to facilitate your healthcare treatment, payment, or for health care operations. By signing this form, you are giving us permission to share your PHI as you indicate below.

I understand that my health care and the payment for my health care will not be affected by my signing this form. I understand that treatment, payment, enrollment or eligibility for benefits will not depend in any way on whether I sign this authorization or not. I further understand that I may inspect and copy any information disclosed pursuant to this authorization, and that I will receive a copy of this form upon signing it if I request it.

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations. I further understand that information disclosed pursuant to this authorization may be re-disclosed by the parties listed below and no longer protected.

I understand that this authorization is voluntary and may be revoked at any time. The request to revoke this authorization must be received by the Practice in writing. I further understand that any such revocation does not apply to the extent that persons authorized to use and/or disclose my health information have already acted upon my previous authorization(s).

Patient/Caregiver Signature:_____**Date:**_____

☐ **I authorize the release of selected medical information to be left on my voicemail.**

☐ **I authorize the release of selected medical information as outlined below:**

List the name of the individual to receive information: _____

Relationship to Patient: ☐ Spouse ☐ Child ☐ Other:_____

Information to be disclosed (Please check all that apply):

☐ Appointment Reminders ☐ Medical Records ☐ Imaging ☐ Financial ☐ Billing/Insurance

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FINANCIAL POLICY

Thank you for choosing Advanced Foot and Ankle. Our staff is dedicated to your comfort. We care about your health and also your well-being and satisfaction. As part of our services we try to maintain reasonable costs, and in an effort to do this, we have implemented a Financial Policy. To avoid any misunderstandings, please contact us if you have any questions about our policies.

INSURANCE: We must have complete and accurate insurance information and a copy of your insurance card on file. If your doctor is a participating provider with your insurance plan, we abide by our contract with them. In either managed care plans or private plans, we will bill your insurance company; however, you are responsible for paying any co-pays, coinsurance and deductibles required by your plan at the time of treatment. Your insurance policy is a contract between you and your insurance company; therefore, you are responsible for payment whether or not your insurance company pays. It is your responsibility to contact your insurance company regarding pre-authorizations, obtaining required referrals, second opinions, etc. Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become your responsibility to pay. All co-payments must be paid at the time of service.

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment. We do accept self-pay patients, please contact our office regarding pricing for services.

PAYMENT: Payments for the balance due, copayments, deductibles, etc., are due at the time of service and may be made by cash, check, or credit card (Visa, Mastercard, American Express, Discover). There will be a $25.00 charge for returned checks. Delinquent accounts will be referred for collection at the discretion of the office manager.

MEDICARE PATIENTS: We accept assignment for Medicare; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any co-payments, which are usually 20% of the allowed amount for an item or service.

MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment. Young adults (age 18 & over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement, regardless of insurance coverage.

MISSED APPOINTMENTS: Please help us serve you by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate all of our patients. We reserve the right to charge for missed appointments.

I have read and agree to the terms set forth in the above financial policy. I hereby authorize payment directly to Advanced Foot and Ankle of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I understand that I am financially responsible for any collection fees should I default on any patient balances. I authorize the doctor and/or provider or supplier of services in this office to release the information required to secure the payment or benefits. I authorize the use of this signature on all insurance submissions.

Patient/Caregiver Signature:_____**Date:** _____

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OFFICE POLICIES

We know how hectic life can be and are committed to making our office convenient and accessible. We hope that these policies will make your appointments as easy and pleasant as possible.

Financial: Financial misunderstandings are the most common reasons for frustration. Please let us know as soon as an issue develops so that we can try to avoid misunderstandings.

Covered: When the staff uses the word "covered" it means that this service, whether a procedure or a piece of medical equipment , is normally paid for by your insurance company. However, even with insurance coverage, fees after coinsurance and deductibles may apply to the patient. Therefore, even though the item is covered, you may still have a bill.

Deductible: The deductible is an amount of money that the patient must pay each year before any insurance benefits will be reimbursed. This means that your insurance company expects you, the patient, to pay the entire bill at the time of service until your deductible is reached. Please understand your deductible and how much you have currently met.

Co-Insurance: This is a percentage that some insurance companies require the insured patient to pay for medical services after their deductible has been met. A common co-insurance patient responsibility is 20%, though this varies significantly between specific procedures or medical equipment.

Co-pay: This is the amount your insurance requires you pay at each office visit and is due at time of service. You cannot be seen unless this fee is paid.

Late for appointment: We try our best to keep scheduled appointment times. If you are more than 15 minutes late, we may be able to work you into the schedule later in the day or we may ask you to reschedule.

Missed Appointments: We understand that sometimes unforeseen scheduling conflicts arise. If you must cancel your appointment, please call our office 24 hours in advance. This allows us to accommodate all of our patients. We reserve the right to charge for missed appointments.

Medical records: The office owns the medical record. It is not the property of a patient. The original copy must always stay in possession of the office. As a patient you may have access to your medical records. We require a signed waiver and two weeks notice to make a copy of your medical record.

Routine foot care: Nail and callus care are not always covered by insurance companies. There is a $50 fee for uncovered nail and callus care, payable at the time of service.

Common courtesy: We want all of our patients to feel safe and comfortable in our office. Please use respectful behavior at all times. We reserve the right to ask anyone to leave if they are creating an unsafe environment and atmosphere.

Cell phone: During office appointments, cell phone calls interrupt the evaluation and treatment process. If you are speaking on the phone during an appointment, our staff will bypass your appointment until you are finished with your phone call.

Treatment Plans: Many foot ailments do not improve after one treatment and may require several weeks or months to improve. Different modalities may be needed depending upon the severity and condition. Multiple visits may be needed for diagnostic testing and treatments.

Medication refills: We try to refill medications over the phone when possible. If you have not been seen in our office within six months, your prescription will not be refilled until your next appointment.

Lab testing, MRIs, and pathology reports: Imaging and testing results take time to be performed and reported to our office. Results will be interpreted by our staff, and we will call you as soon as possible. Please allow one week for non-urgent results and test scheduling.

PATIENT CONSENT: I hereby consent to evaluation encompassing routine care, diagnostic procedures, examination, testing, and treatment as directed by Advanced Foot and Ankle physicians or designees. Including but not limited to; minor surgical procedures, routine laboratory work, x-rays, ultrasound, photographs and administration of medications and injections prescribed by the podiatrist. I agree to ask questions to clarify treatment should I not understand the treatment plan.

Patient/CaregiverSignature:_____**Date:**_____

What is the reason for your visit today? _____

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On a scale of 1-10, rate your pain (10 being the worst): 1 2 3 4 5 6 7 8 9 10

How long has this bothered you? _____

Have you experienced any trauma or injury to the area?_____

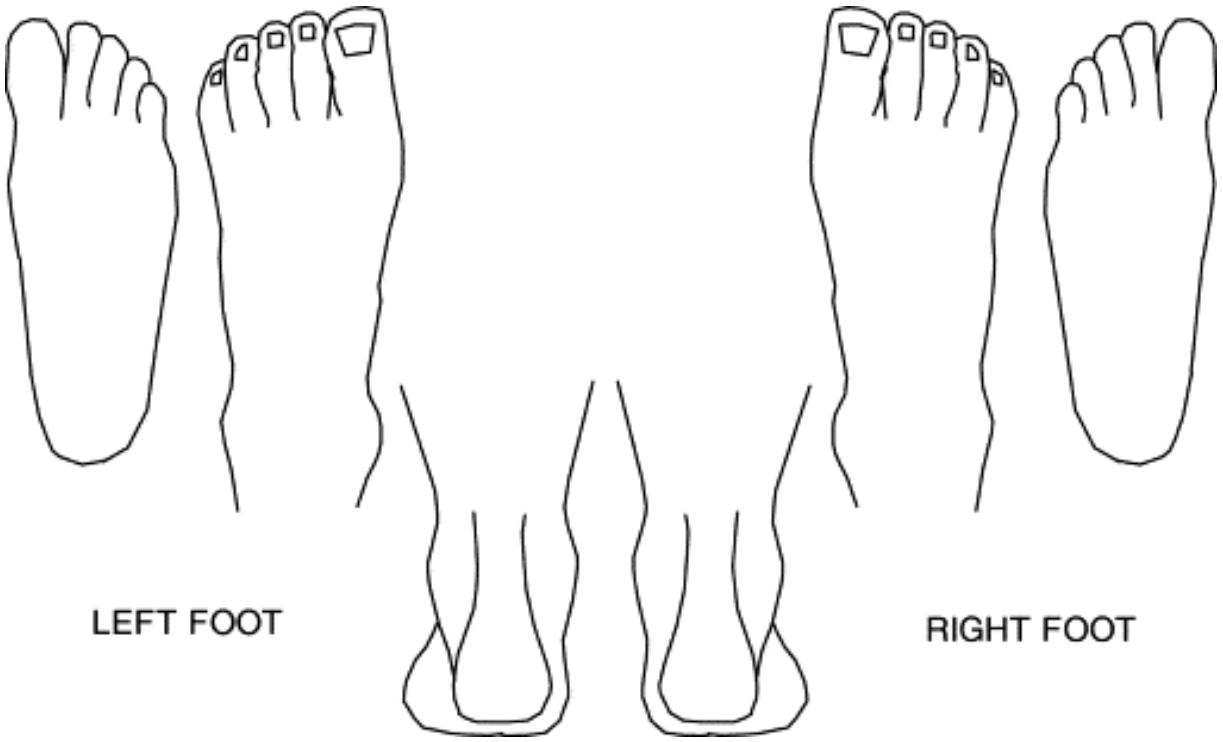
What treatments have you tried/failed? _____

What treatments have helped?_____

Describe the pain: burning numbness tingling constant dull sharp stabbing shooting throbbing tearing electrical
Other: _____

What makes the pain worse? Running Walking Standing Certain Shoes Elevation Touching/Rubbing
Other:_____

Please circle where on your feet/ankles you are having pain.



For Office Use:
BP: _____ **Pulse**: _____ **Height**: _____ **Weight**: _____ **Shoe Size**:_____

IMMUNIZATIONS: Tetanus_____ Pneumonia_____ Seasonal Flu_____ Other _____

Primary Care Provider: _____**Date Last Seen:**_____

MEDICAL AND FAMILY HISTORY: *(Check all that apply)*

	You	Mother	Father	Siblings
AIDS/HIV				

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Alcoholism				
Anemia				
Anxiety/Depression				
Arthritis				
Atrial Fibrillation				
Asthma				
Back Pain				
Bacterial Infection				
Blood Clots				
Bleeding Problems				
Cancer (type)_____				
Congestive Heart Failure				
Circulation Problems				
COPD				
Developmental Delay				
Diabetes Type I or II				
Diabetic Retinopathy				
Digestive Disorders: Acid Reflux, Ulcers, IBS, etc.				
Emphysema				
Fall Risk				
Fibromyalgia				
Gout				
Heart Disease/Murmur				
Hypothyroidism				
Hepatitis				
High Cholesterol				
High Blood Pressure				
Kidney Disease				
Liver Disease				
Lyme Disease				
Migraines				
Memory Loss				
Multiple Sclerosis				
Neuropathy				
Obesity				
Osteoarthritis				
Psoriatic Arthritis				
Respiratory Problems				
Rheumatoid Arthritis				
Restless Leg Syndrome				
Skin Disorders				
Stroke				
Traumatic Brain Injury				
UTI				
Other:				

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SURGICAL HISTORY:

Have you ever had any surgical procedure on your foot/ankle? Yes / No.
If yes, please describe:_____

MEDICATION: *(Provide copy of medication list)*

PHARMACY: *(Location)*

ALLERGIES:

SOCIAL HISTORY:

Tobacco Use: Never / Former / Currently How many packs/day? _____ For how many years? _____ Quit Date: _____ Are you interested in quitting? Yes / No
Alcohol Use: Never / Former / Occasionally / Heavily How many drinks/day? _____ For how many years? _____ Quit Date: _____ Are you interested in quitting? Yes / No

CURRENT SYMPTOMS: *(Please check all current symptoms)*

Cardiovascular	o Edema o Cold Feet/Hands	o Leg pain o Cramps	o Palpitations o Chest Pain	o None
Gastrointestinal	o Abdominal pain o Blood in stool o Constipation	o Loss of appetite o Diarrhea o Heartburn	o Vomiting o Ulcers o Jaundice	o None
Genitourinary	o Blood in urine o Incontinence	o Burning o Painful	o Urgency o Frequency	o None
Integumentary	o Hair Loss o Rash o Dry Skin	o Ingrown Toenail o Nail Changes o Growths	o Lesions o Ulcers o Warts	o None
Musculoskeletal	o Muscle/Joint Pain o Inflammation	o Redness o Warmth	o Loss of motion o Stiffness	o None
Neurological	o Numbness o Tingling o Burning	o Balance Problems o Weakness o Memory Loss	o Dizziness o Tremors o Seizures	o None
Respiratory	o Short of Breath	o Coughing	o Wheezing	o None