ADVANCED FOOT & ANKLE SPECIALISTS OF AZ DATE:______________

(FORM MUST BE COMPLETED)

Patient Name:(Last/First/MI)_________________________/_________________________/__________

DOB:______/______/______ Age:______ Shoe Size:______ Male:______ Female:______

Social Security #:________-________-________ Marital Status: S M D W

Address:______________________________ City:____________ State:________ Zip:____________

Home Phone:(_____)______-________ Cell Phone:(_____)______-________ Work Phone:(_____)_____-_______

E-Mail:____

Employer:____

Winter/Secondary Address:____

Emergency Contact Name:__________________________________ Phone:(______)________-_________

Primary Insurance:_______________________ ID #:____________________ Group #:____________

Policy Holder's Name:____ DOB:______/______/______

Address:__________________________________ City:______________ State:________ Zip:__________

Social Security #:________-________-________ Relationship to Patient: Self Spouse Parent Other

Secondary Insurance:_________________________ ID #:__________________ Group #:____________

Policy Holder's Name:____ DOB:______/______/______

Address:_________________________________ City:______________ State:________ Zip:___________

Social Security #:_________-_________-_________ Relationship to Patient: Self Spouse Parent Other

Responsible Party's Name (if other than patient):____

Address:____

City:___________________________ State:__________ Zip:____________ Phone:(_____)______-________

Who is your Primary Care Physician:_____________________________ Phone:(______)________-_________

How did you hear about us? Please circle one:

PCP / Family / Friend / Google / Insurance Website / Yelp / Facebook / Community Event / Other:________________

Pharmacy Name:____ Phone:(______)________-_________

<u>NOTICE** PLEASE READ AND SIGN</u>**

I HEARBY ACKNOWLEDGE THE RECEIPT OF THE NOTICE OF PRIVACY FOR **ADVANCED FOOT & ANKLE SPECIALISTS OF ARIZONA**. I AUTHORIZE THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS AND ANY INFORMATION PERTINENT TO MY MEDICAL CARE.

I UNDERSTAND THAT FAILURE TO GIVE 24-HOUR NOTICE OR FAILURE TO KEEP SCHEDULED APPOINTMENTS **WILL** RESULT IN A NO-SHOW CHARGE OF $50.00. LATE CANCELLATION OF APPOINTMENT **WILL** RESULT IN A CHARGE OF $30.00.

Patient/Responsible Party's Signature:____ Date:______________

(FORM MUST BE COMPLETED)

Patient Name:____ **DOB:**______/______/______

Drug/Other Allergies:____

Reason For Initial Visit:____

Preferred Language: English Spanish French Other Decline

Race: Caucasian African American Native American Hispanic Asian Other Decline

Social History

Tobacco Use	Never____	Former Smoker____	Current Smoker_____	How Long_____	Packs/day__
Alcohol Use	Never____	Previous____	Occasional____	Drinks per day_______	
Illicit Drug Use	Never____	Previous____	Occasional____	Type of use_________	

Personal Medical History (Circle All That Apply)

Diabetes Hypertension Cardiac/Heart Disease Osteoarthritis Rheumatoid Arthritis

Asthma Kidney Disease Liver Disease Hepatitis Gastrointestinal Disease GERD

Thyroid Disease Cancer Stroke Seizures CVA Blood Clots Myocardial Infarction

Hyperlipidemia Fibromyalgia Depression Bipolar RSD/CRPS HIV/AIDS STD

Gout Osteomyelitis Leg/Foot Ulcers Ankle Fractures Foot/Toe Fractures Ingrown Nails

Family History

____

____

Past Surgeries

____

____

Medications with Dosages

____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND/OR INFORMATION

I authorize the release of photocopies of the following medical records and/or x-ray films in the possession or control of Advanced Foot & Ankle Specialists of Arizona, PLLC, its employees and/or agents. FOR THE PURPOSE HEREOF, "MEDICAL RECORDS AND X-RAY FILMS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION (AS DEFINED IN R.R.S. SECTION 36-3661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE RELATED INFORMATION (AS DEFINED IN 42 (FR SECTION 2.1 ET SEQ), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

I authorize Advanced Foot & Ankle Specialists of Arizona, PLLC, to release medical information and/or discuss all matters related to my treatment or care to the entities indicated below. I understand that confidentiality cannot guaranteed.

Primary Care Physician: ______________________________

Other Physicians: ______________________________

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Family and/or Other Persons: (Please list name and relationship)

Name: ______________________________Relationship________________

______________________________Relationship________________

I authorize Advanced Foot & Ankle Specialists of Arizona, PLLC, to leave results or detailed messages on the below number:

Phone Number: ______________________________Hours:________________

Patient Signature:______________________________ Date:________________

Advanced Foot & Ankle Specialists of Arizona

Financial Policy

Thank you for choosing us as your podiatrist. We are committed to providing you with quality and affordable health care. In order to reduce misunderstandings, we have adopted the following Financial Policy. We require that you carefully read, initial each numbered section, and sign the bottom prior to the start of any service or treatment.

1. Insurance: If you are insured by a plan we are not in-network and contracted with, payment in full is expected at each visit. If we accept your insurance but you don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. It is your responsibility to know your insurance benefits including deductibles, co-insurances, and copays as well as contracted labs, radiology and hospital facilities. Please contact your insurance company with any questions you may have regarding your coverage. It is your responsibility to notify our office of any change in your insurance coverage. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy benefits and coverage will be verified by our office, however, the explanation we are given is not a guarantee and until your claim is processed there is no guarantee of any coverage. These are guidelines set forth by your insurance company directly.

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2. Co-Payments, Deductibles & Co-Insurance: All co-payments, deductibles and/or co-insurances must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments can be considered fraud. Patients with deductibles and/or co-insurances are expected to pay 100% of the contracted rate for covered services at the end of each visit. A copay will be collected at each visit.

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3. Non-Covered Services: All health plans are not the same, and they do not always cover the same services. Please be aware that some of the services you receive may be determined to be "not covered" by your health plan. You must pay for these services in full and a quote may be given prior to any treatment or service.

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4. Proof of Insurance: We will bill your insurance on the information you provide us at the time of service. This requires us to copy your current insurance card. We will also require you to confirm your registration information. Your failure to provide us with the correct information could result in the denial of your claim. If this occurs, you assume responsibility for the entire amount of the claim.

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5. Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. If your insurance company does not pay your claim within 60 days, the balance will automatically be billed to you.

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6. Billing Statements: Patient balance statements are mailed out on a monthly basis. Please make sure we are informed of your current address. In addition, patients with scheduled appointments will also be expected to pay any outstanding statements due. A fee of $75 will apply to any bounced checks.

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7. Past Due Balances: Any unpaid balances after 2 billing cycles will be sent to collections. An additional fee of 35% will be added to your account balance. In order to be seen after an account is sent to collections, balance must be paid in full along with $50 re-instatement fee.

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8. No Show / Late Cancellation Fees: We charge $50 for missed appointments and $30 for appointments not cancelled with at least 24 hr notice. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointment.

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9. Minors: A parent/legal guardian must accompany a minor patient on his first visit to our office so we can obtain a signature to treat the minor patient. A minor may be treated on subsequent visits without a parent/guardian only if we have a notarized written consent. The adult accompanying the minor patient is responsible for the payment of the rendered service at the time of service.

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Miscellaneous Charges:
FMLA $25
Disability Forms $25-50 (physician discretion)
Legal Forms $25-300 (physician's discretion) __________

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. A copy will be available upon request.

I have read and understand this payment policy. By signing below you agree to these terms.

____ __________________

Signature of Patient or Responsible Party Date