ADVANCED FOOT & ANKLE SPECIALISTS OF AZ

DATE: ___/____/____

(FORMS MUST BE FILLED OUT COMPLETELY)

Patient Name: (Last/First/MI) _____/_____/_____

Patient DOB: ____/____/____ Age: _____ Male: _____ Female: _____ Shoe Size: _____

Social Security #: _____/_____/_____ Marital Status (Circle) : Single Married Divorced Widowed

Current Address: _____ City: _____ State: _____ Zip: _____

Phone Home: _____-_____-_____ Cell: _____-_____-_____ Work: _____-_____-_____

Contact you at which phone # above during clinic hours? (Circle One): Home Cell Work

Email Address: _____ Current Employer: _____

Emergency Contact: _____ Phone: _____-_____-_____ Relationship: _____

*Primary Insurance: _____ ID#: _____ Group#: _____

Does your insurance require a Referral? YES NO Authorization? YES NO

*If yes above - Have you confirmed that the Referral or Authorization has been received? YES NO

Policy Holders Name (If other than patient): _____ DOB: _____/_____/_____

Current Address: _____ City: _____ State: _____ Zip: _____

Social Security#: _____/_____/_____ Relationship to patient: Spouse Parent Other

*Secondary Insurance: _____ ID#: _____ Group#: _____

Policy Holders Name (If other than patient): _____ DOB: _____/_____/_____

Current Address: _____ City: _____ State: _____ Zip: _____

Social Security#: _____/_____/_____ Relationship to patient: Spouse Parent Other

How did you hear about us? (Circle One) PCP / Other Physician / Family / Friend / Google / Yahoo

Yelp / Facebook / Ins Website / Community Event / Other

Primary Care/Other Ref Dr Name: _____ Phone: _____-_____-_____

Pharmacy Name: _____ Location: _____ Ph#: _____-_____-_____

***NOTICE**PLEASE READ AND SIGN

I HEREBY ACKNOWLEDGE THE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES 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-HR NOTICE TO CANCEL MY SCHEDULED APPOINTMENTS WILL RESULT IN A LATE CANCEL FEE OF $30.00. ANY SCHEDULED APPOINTMENTS THAT ARE MISSED/NO SHOW WILL RESULT IN A FEE OF $50.00

*If Patient is a minor child, who is the Responsible Party? (Please Print Name) _____

Patient/Responsible Party's Signature: _____ Date: _____/_____/_____

ADVANCED FOOT & ANKLE SPECIALISTS of Arizona

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND/OR INFORMATION

I authorize the release of photocopies of the following medical records and/or radiology 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 RADIOLOGY FILMS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION AND COMMUNICABLE DISEASE RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE RELATED INFORMATION (AS DEFINED IN 42 FR SECTION 2.1 ET SEQ), AND ANY CONFIDENTIAL MENTAL HEALTH DIAGNOSIS OR 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 be guaranteed. I understand no information can be released to my family members or spouse (including billing information) without my written consent.

Primary Care Physician: _____

Other Physicians: _____

_____

Family and/or Other Persons: **(List Full Name and relationship)**

Name: _____ Relationship: _____

_____ _____

_____ _____

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

Phone Number: _____ Hours: _____

Patient/Responsible Party Signature: _____ **Date:** ____/____/____

(MEDICAL HISTORY FORM MUST BE COMPLETED) Today's Date: ___/___/___

Patient Name: _____ DOB: _____/_____/_____

Reason For Initial Visit: _____ (Right /Left / Bilateral)

Drug/Other Allergies: _____ Influenza Vaccine past 12 mo? Yes No

(Patients over 60 yrs) Have you had a pneumococcal vaccine since turning 60? Yes No

Have you had Covid19? Yes, When ? _____ No Have you had Covid Vaccine? Yes No

Preferred Language:(Circle One) English Spanish French Other Decline

Race:(Circle One) Caucasian - African American - Native American - Hispanic - Other - Decline

Social History (Circle)

Tobacco Use: Never Previous Current Smoker - How long___yr Packs/day____

Alcohol Use: Never Previous Current Use - Drinks per day ____ or week _____

Illicit Drug Use: Never Previous Current Use - 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 Fractures Ankle / Foot / Toe Ingrown Nails

Family Illness History

_____

Past Surgeries

_____

Medications with Dosage

_____

_____

ADVANCED FOOT & ANKLE SPECIALISTS OF ARIZONA
FINANCIAL POLICY

Thank you for trusting our physicians and choosing us for all your podiatry needs. 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 do require that you carefully read, initial each numbered section, and sign the bottom of this form prior to the start of any services or treatment.

1. **Insurance:** If you are insured by a plan we are not contracted with or considered "out-of network " payment in full is expected at each visit. If we accept your insurance but you do not have an updated 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-insurance, copays, etc. as well as your contracted laboratories, hospitals and radiology facilities. Please contact your insurance company with any questions you may have regarding your coverage. It is your responsibility to notify our office immediately of any change in your coverage. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, our office does attempt to verify benefits and coverage however, the explanation of coverage/benefits that we are given is not a guarantee. These are guidelines set forth by your insurance company directly. You are responsible for all charges that are unpaid by your insurance.

_____

2. **Copayments/Deductibles/Co-Insurance**: All copayments, co-insurance, deductibles or other patient estimated financial responsibility is due and payable at the time of service. This arrangement is a part of your contract with your insurance company. Failure on our part to collect these payments can be considered fraud by the insurance companies which we are considered "contracted providers".

_____

3. **Non Covered Services:** All health plans are not the same and do not always cover the same services. Please be aware that some of the services you receive may be determined to be "non covered" by your particular health plan. Any services provided at your visit will be your responsibility and a quote may be given to you by our office at the time of treatment.

_____

4. **Proof of Insurance:** Your insurance will be billed with the information you provided us either when you scheduled your appointment or at the time of service. This requires us to have a copy of your insurance card along with proper proof of identification. Failure to provide us with the complete correct information could result in a denial of your

_____

5. **Claims Submission:** We will submit your claims and assist you in any way reasonably possible to get your claim paid. Your insurance company may need you to supply certain information directly. If your insurance company does not pay your claim within 60 days, for any reason, that balance will be your responsibility.

_____

6. **Billing Statements:** Patient balance due 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. No checks are accepted in person at our office (Cash/Debit/Credit only) If any check payments that are mailed into our office are returned from your bank for any reason, you will be charged an additional $75.00 fee in addition to the statement that is still due.

_____

7. **Past Due Balances:** Any balances due after 2 billing cycles will be sent to collections. An additional fee of 35% will be added to your account balance. In order to schedule an appointment in our office after an account is sent to collections, the account must be paid in full along with a $50.00 reinstatement fee.

_____

8. **No Show / Late Cancellation Policy**: Anytime you schedule an appointment with our office we have set that time "aside for you" If you fail to give us 24-hr notice to cancel your appointment, you will be assessed a $30.00 late cancellation fee. If you fail to present for your appointment or do not contact us at all or until after your scheduled time, you will be assessed a $50.00 no show fee.

_____

9. **Minors (anyone under 21)**: A parent or legal guardian must accompany minor patients on his/her initial visit so we may obtain a signature/authorization to treat the patient. A minor child may receive treatment on subsequent visits without a parent/legal guardian present but only after we have received proper consent for another individual that will be accompanying the patient. Any person presenting with a minor for treatment must be an adult (over 21 years).

_____

Miscellaneous Service Fees:

FMLA Completion Forms - $30.00
Disability Form Completion - $25.00 - $50.00 (physician's discretion)
Legal Forms - $25.00 - $300.00

_____

Our practice is committed to providing the highest quality of care to all our patients. Our prices/charges are representative of the usual and customary charges for our area.

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

I have read and understand this financial policy. By signing below, I agree to these terms.

_____ _____

Signature of Patient or Responsible Party Date