Welcome/*Bienvenido*

Thank you for selecting our podiatric care team! We will strive to provide you with the best possible foot care. To help us meet all of your foot care needs, please fill out this form completely in ink.

Gracias por escogernos como su grupo podiatra! Nos esforzamos en proveerle con el mejor cuidado para sus pies. Para ayudarnos brindarle el mejor tratamiento, por favor llene el formulario por completo usando un lapicero.

Patient Information/ *Informacion Del Paciente*

Last Name/ *Apellido* ______________________ **First Name/***Primer Nombre* ______________________ **MI/** *Segundo Nombre* ____

Home Address / *Direccion* ____

City/*Cuidad*, **State**/*Estado*, **Zip Code** / *Codigo Postal* ____

Phone#/*Telefono:* **(H)** *Casa* ________________ **(W)** *Trabajo* ________________ **(C)** *Cellular* ________________

SS#/*Seguro Social#* **Age**/*Edad* **Date of Birth**/*Fecha De Nacimiento* / / **Sex** / *Sexo* **M / F**

Employer/*Trabajo* **Occupation** / *Occupacion*

Email/ *Correo Electronico*

Emergency Contact/*Contacto De Emergencia* ***Phone#*** **Relationship/** *Relacion*

Financial Information / *Informacion Financial*

Please circle which applies: **INSURANCE / SELF PAY / WORKERS COMPENSATION (SEE FRONT DESK)**

Primary Insurance	**Secondary Insurance**	**If different from patient:**
Type:	Type:	Name of Insured:
Policy # ________	Policy # ________	Date of Birth: ________
		Relationship to Patient: ________

How did you learn about our practice? / *Como aprendio de la Practica?*

Pharmacy Information / *Informacion de Farmacia*

Do you have a preferred pharmacy? / *Tiene farmacia preferida?* **YES** *(SI)* / **NO**

Pharmacy Name / *Nombre de farmacia?* **Phone # /** *Telefono #* ________________

Address / *Direccion?* ____

Primary Care Physician (PCP) Name, Address, Phone# / *Su Doctor Primario, Nombre, Direccion, Numero de telefono:*

____

What is your primary reason for today's visit and a brief description of the problem? (CIRCLE ONE) **LEFT / RIGHT**
Cual es las razon principal para su visita hoy y de una descripcion del problema? (HAGA UN CIRCULO AL LUGAR) IZQUIERDO / DERECHO

Medical History (i.e. Diabetes, High Blood Pressure, Arthritis) / *Historial Medico (Diabetes, Presion Arterial, Artritis)*

____

____

Are you currently taking any medications? (Include any vitamins or supplements) / If YES please list:
Esta tomando actualmente algun medicamento? (Incluye vitaminas y suplemento) Si la repuesta es Si por favor enumere:

____

Allergies: **(CIRCLE ALL THAT APPLY) /** *Alergias (HAGA UN CIRCULO A TODO QUE CORRESPONDE)*
Aspirin / Codeine / Iodine / Novocaine / Penicillin / Tape / Other *Aspirina / Yodo / Novocaina / Penicillina / Cinta / Otro*

Social History / *Historia Social*

Circle all that apply: Tobacco: YES / NO
CURRENT / FORMER
Alcohol: YES / NO
Exercise: YES / NO
What kind of exercise/activity?
____

Haga un circulo a todo que coresponde: *SI / NO*
ACTUAL / ANTERIOR
Alcohol: *SI / NO*
Ejercicio: *SI / NO*
Que tipo de ejecicio / actividad?
____

I understand the medical information provided is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Yo entiendo que la informacion que me han dado es necessario para el servicio medical y el cuidado que necesito de bien rendimiento. Yo he contestado todas la preguntas con todo mi conocimiento. Si necesita mas informacion, yo le doy permiso para que pueda localizar las respuestas de mis otros doctors o agencias. Yo le aviso si hay cambios en mi salud o medicamento.

Would you like us to send a letter to your PCP concerning your evaluation and treatment today? YES / NO
Usted quiere que le mandemos una carta de su tratamiento hoy a su doctor primario? SI / NO

Patient/Guardian Signature: *X* **Date /** *Fecha:*
Firma del paciente / persona encargada:

Authorization for Payment / *Autorizacion De Pago*

I hereby authorize payment of Medicare or other insurance benefits made to my physician for any services furnished to me by that physician. I authorize any holder of medical information about me to release any and all information needed to determine these benefits payable for related services. Furthermore, I understand and agree that I am ultimately responsible (regardless of my insurance status) for the balance on my account for any professional services rendered and that possessing the above insurance information is not a guarantee of coverage.

I have read all of the information on this form and answered all questions to the best of my knowledge. I will notify this office of any changes in my health status or changes in the information provided.

Yo autorizo pago de Medicare or otros beneficios de seguro echos para mi medico para servicios que mi medico me a rendido. Yo autorizo liberacion de cualquiera informacion medical or tratamiento mio que afecte le determinacion de los pagos de beneficios de seguro para servicios rendidos. Yo estoy de acuerdo y entiendo que yo soy responsible por cualquier servicio professional rendido que los beneficios de seguro no estan garantizado de cubrir.

Yo he leido toda la informacion en este documento y he contestado todas las preguntas de conocimiento. Yo le informaro a esta oficina de cualquier cambio di mi salud o informacion dado en este documento.

X ____________________	X ____________________	X ____________________
Print patient name / authorized representative *Imprime nombre de paciente / representante con autorizacion*	**Signature of patient / authorized representative** *Firma del paciente /representante con autorizacion*	**Date** *Fecha*

Managed Care Insurance Plans / *Seguro De Manage Care Plans*

If you have a Managed Care type of insurance that requires a referral for each visit, it is YOUR responsibility to obtain this before our visit. If you have not received the proper authorization as per office policy, you will NOT be seen. If you choose to be seen by a physician, you will be responsible for the entire fee of ALL services rendered at the time of the visit.

I have read and understand the Office Policies regarding Managed Care Insurance Plans.

Si usted tiene algun clase de seguro que necesita referido antes de ver al doctor para cada visita, es SU responsabildad conseguir ese referido antes de la visita. Es la poliza de esta oficina que si no adquirido referido o autorizacion correcto no puede ver al doctor. Si usted escoge ver al doctor sin referido, usted es responsable por la cuenta de visita y servicio rendido.

Yo he leido y entiendo la poliza de esta oficina sobre el seguro de Managed Care Plans.

X ____________________	X ____________________	X ____________________
Print patient name / authorized representative *Imprime nombre de paciente / representante con autorizacion*	**Signature of patient / authorized representative** *Firma del paciente /representante con autorizacion*	**Date** *Fecha*

Acknowldgement of Receipt of Notice of Privacy Practices/ *Reconocimiento Del Aviso De La Practica Privada*

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Yo reconosco el recibo del aviso de la practica privada de la oficina y lo he leido y entiendo el aviso.

X ____________________	X ____________________	X ____________________
Print patient name / authorized representative *Imprime nombre de paciente / representante con autorizacion*	**Signature of patient / authorized representative** *Firma del paciente /representante con autorizacion*	**Date** *Fecha*

I understand that Foot and Ankle Care Premier Specialists expect payment at the time of service unless prior arrangements have been made. I understand that I am financially responsible for all charges not covered by insurance and I guarantee the balance to be paid by my credit card, check, or cash. Past due balances may be subject to additional fee's.

Yo entiendo que soy financialmente responsible de pagar la deuda para la consulta a Foot and Ankle Care Premier Specialists, a menos que hiso un acuerdo con la oficina. Yo entiendo que soy financialmente responsible de pagar la cuenta/deuda si mis beneficios de seguro no lo cubre y yo garantizo el pago en forma de credito, cheque, o dinero. Sobre el tema balance viejo tiene un precio addiconal.

Initial/ Date / *Ponga su inicial/ fecha*

In the event that you undergo surgery in a hospital or ambulatory surgery center, a separate charge will be made by that facility. Your podiatric physician at Foot and Ankle Care Premier Specialists may have financial interest in a surgery center where you will be having your surgery.

Si por alguna razon usted consiga sirugia en un hospital o centro de sirugia, le vendra una cuenta diferente de ese edificio. Tal voz su podiatra en Foot and Ankle Care Premier Specialists tiene interes financial en el lugar diferente donde usted va a hacer la sirugia.

Initial/ Date / *Ponga su inicial/ fecha*

PAYMENT POLICY

1. **INSURANCE:** We participate with most insurance plans, including Medicare. If you are insured by a plan we participate with and don't have an up to date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance plan is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **CO PAYMENTS AND DEDUCTIBLES:** All co payments and deductibles must be paid at the time of service. Co payments and deductibles amounts are updated each visit. You are responsible for payments the day services are rendered.
3. **NON COVERED SERVICES:** Please be aware that some and perhaps all of the services you receive may be non covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit.
4. **PROOF OF INSURANCE:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's licenses and current valid insurance to provide proof of insurance. If you fail to provide us correct insurance information in a timely manner you will be responsible for payment of the office visit.
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. It's your responsibility to comply with their request. If your insurance changes, please notify us before your next appointment so we can make the appropriate changes to help you receive maximum benefits.
6. **NON PAYMENT:** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware if your account balance remains unpaid, we refer your account to a collection agency.
7. **MISSED APPOINTMENTS:** Our policy is to charge $25.00 for appointments not canceled within 24 hours in advance. These charges will be your responsibility and charge directly to you. Please help us to serve you better by keeping your scheduled appointment.

Please let us know if you have any questions and/or concerns.

I have read and understand the payment policy and agree to abide by the guide lines.

______________________________________ ______________________

Signature of Patient or Responsible Party **Date**