Madison Advanced Foot & Ankle

New Patient Forms

PATIENT LEGAL NAME: _____ MI: _____ LAST: _____

DATE OF BIRTH: _____/_____/_____ MALE/FEMALE SOCIAL SECURITY#: _____-_____-_____

WHAT IS THE MAIN NUMBER YOU WOULD LIKE US TO USE: CELL HOME WORK

CELL#: (_____) _____-_____ HOME# (_____) _____-_____ WORK#: (_____) _____-_____

PATIENT BILLING ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PRIMARY CARE DOCTOR: _____WHO REFERRED YOU TO DR. COLIN GRANEY? _____

MARITAL STATUS: (CIRCLE) SINGLE/MARRIED/DIVORCED/LEGALLY SEPARATED/WIDOWED

Height: _____ft_____in Weight: _____lbs

ETHNICITY: (CIRCLE) HISPANIC OR LATINO/NON HISPANIC OR LATINO/DECLINED TO SPECIFY

RACE: (CIRCLE) WHITE/AFRICAN AMERICAN/ASIAN/ AMERICAN INDIAN/ALASKA NATIVE/NATIVE HAWAIIAN/OTHER PACIFIC/DECLINED TO SPECIFY

PRIMARY LANGUAGE: (CIRCLE) ENGLISH/SPANISH/OTHER_____

PATIENT EMPLOYMENT STATUS: (CIRCLE) FT/PT/NOT EMPLOYED/SELF EMPLOYED/DISABLED/RETIRED (DATE): ____/____/____

EMPLOYER: _____ VETERAN: YES/NO ACTIVE DUTY: YES/NO STUDENT (CIRCLE) FT/PT

PRIMARY INSURANCE CARRIER: _____

POLICY#: _____ GROUP# _____

PHONE NUMBER: _____ SPECIALIST COPAY $ _____

SECONDARY INSURANCE CARRIER: _____

POLICY#: _____ GROUP# _____

PHONE NUMBER: _____ SPECIALIST COPAY $ _____

IF PRIMARY INSURANCE HOLDER IS NOT PATIENT OR GUARDIAN INFORMATION:

PRIMARY HOLDER IS: (CIRCLE) SPOUSE/MOTHER/FATHER OTHER: _____

LEGAL NAME: _____ DOB: _____/_____/_____

PRIMARY HOLDER ADDRESS: (IF NOT THE SAME AS PATIENT ADDRESS): _____

CITY: _____ STATE: _____ ZIP: _____ SOCIAL SECURITY #: _____-_____-_____

EMPLOYMENT STATUS: (CIRCLE) FT/PT/NOT EMPLOYED/SELF EMPLOYED/DISABLED/RETIRED (DATE): _____/_____/_____

EMPLOYER: _____EMPLOYER PHONE #: (_____) _____-_____

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PREFERRED PHARMACY: _____ LOCATION: _____ PHONE (_____) _____-_____

HIPAA PATIENT CONTACT CONSENT

OUR AUTOMATED PHONE SERVICE WILL CONTACT YOU AT THE MAIN PHONE NUMBER WE HAVE LISTED FOR YOU REGARDING FUTURE APPOINTMENTS 24 HOURS IN ADVANCE.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (PLEASE CHECK ALL THAT APPLY):

- ☐ **CELL#: (_____) _____-_____**
- ☐ **HOME# (_____) _____-_____**
- ☐ **WORK#: (_____) _____-_____**

MAY WE LEAVE APPOINTMENT INFORMATION VIA TEXT, ANSWERING MACHINE/VOICEMAIL? YES OR NO
MAY WE LEAVE BILLING INFORMATION ON YOUR ANSWERING MACHINE/VOICEMAIL? YES OR NO
MAY WE LEAVE MEDICAL INFORMATION ON YOUR ANSWERING MACHINE/VOICEMAIL? YES OR NO
EXCLUSIONS: _____

WHEN AVAILABLE, WOULD YOU LIKE TO BE ABLE TO CONTACT THE OFFICE THROUGH SECURE ELECTRONIC MESSAGING VIA EMAIL? YES OR NO EMAIL ADDRESS: _____@_____

I GIVE PERMISSION TO SHARE THE FOLLOWING INFORMATION WITH THE FOLLOWING:

EMERGENCY CONTACT PERSON 1: _____ RELATION: _____

CELL#: (_____) _____-_____ HOME# (_____) _____-_____ WORK#: (_____) _____-_____

THIS PERSON IS GRANTED FULL ACCESS TO MY PERSONAL MEDICAL HEALTH INFORMATION? YES OR NO
PICKING UP MEDICATIONS? YES OR NO
APPOINTMENT INFORMATION? YES OR NO
BILLING INFORMATION? YES OR NO

EMERGENCY CONTACT PERSON 2: _____ RELATION: _____

CELL#: (_____) _____-_____ HOME# (_____) _____-_____ WORK#: (_____) _____-_____

THIS PERSON IS GRANTED FULL ACCESS TO MY PERSONAL MEDICAL HEALTH INFORMATION? YES OR NO
PICKING UP MEDICATIONS? YES OR NO
APPOINTMENT INFORMATION? YES OR NO
BILLING INFORMATION? YES OR NO

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SOCIAL HISTORY

Tobacco

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Heavy tobacco smoker
- ☐ Light tobacco smoker
- ☐ Never smoker
- ☐ Smoker, current status unknown
- ☐ Unknown if ever smoked

Alcohol

- ☐ Do not drink
- ☐ Drink daily
- ☐ Frequently drink
- ☐ Hx of Alcoholism
- ☐ Occasional drink

Drug Abuse

- ☐ IVDU
- ☐ Illicit drug use
- ☐ No illicit drug use

Cardiovascular

- ☐ Eat healthy meals
- ☐ Regular exercise
- ☐ Take daily asprin

Safety

- ☐ Household Smoke detector
- ☐ Keep Firearms in home
- ☐ Wear seatbelts

Sexual Activity

- ☐ Exposure to STI
- ☐ Homosexual encounters
- ☐ Not sexually active
- ☐ Safe sex practices
- ☐ Sexually active

Birth Gender

- ☐ Male
- ☐ Female
- ☐ Undifferentiated

FAMILY HISTORY

RELATIONSHIP	LIVING YES/NO	AGE	MAJOR MEDICAL PROBLEMS/CAUSE OF DEATH
FATHER			
MOTHER			
SIBLING(S)			
CHILDREN			

HAVE YOU HAD ANY OF THE FOLLOWING PROCEDURES (CHECK ALL THAT APPLY)

- ☐ Aneurysm repair
- ☐ Appendectomy
- ☐ Back surgery
- ☐ Bariatric surgery/gastric bypass
- ☐ Bilateral tubal ligation
- ☐ Breast resection/mastectomy
- ☐ CABG
- ☐ Carotid endarterectomy/stent
- ☐ Carpal tunnel release surgery
- ☐ Cataract/lens surgery
- ☐ Cesarean section
- ☐ Cholystectomy/bile duct surgery
- ☐ Dilation & curettage
- ☐ Hemorrhoid surgery
- ☐ Hip arthroplasty
- ☐ Hip replacement
- ☐ Hysterectomy
- ☐ Inguinal hernia repair
- ☐ Knee arthroplasty
- ☐ LASIK
- ☐ Laminectomy
- ☐ Nasal surgery
- ☐ PTCA/PCI
- ☐ Pacemaker/defibrillator
- ☐ Prostate surgery
- ☐ Prostatectomy
- ☐ Rotator cuff surgery
- ☐ Sinus surgery
- ☐ Skin cancer excision
- ☐ Spinal fusion
- ☐ TAH-BSO
- ☐ TURP
- ☐ Tonsillectomy/Adenoidectomy
- ☐ Vasectomy

Other Procedures: _____

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PERSONAL HEALTH HISTORY (CHECK ALL THAT APPLY)

Head
- ☐ Trauma

Eyes
- ☐ Blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Wears glasses/contacts

Ears
- ☐ Hearing aids

Nose/Sinuses
- ☐ Allergic Rhinitis
- ☐ Sinus infections

Mouth/Throat/Teeth
- ☐ Dentures

Cardiovascular
- ☐ Aneurysm
- ☐ Angina
- ☐ DVT
- ☐ Dysrhythmia
- ☐ HTN
- ☐ Murmur
- ☐ Myocardial infarction
- ☐ Other heart disease

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD - Bronchitis/Emphysema
- ☐ Pleuritis
- ☐ Pneumonia

Gastrointestinal
- ☐ Cirrhosis
- ☐ GERD
- ☐ Gallbladder disease
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hiatal hernia
- ☐ Jaundice
- ☐ Ulcer

Genitourinary
- ☐ Hernia
- ☐ Incontinence
- ☐ Nephrolithiasis
- ☐ Other kidney disease
- ☐ STDs
- ☐ UTI(s)

Musculoskeletal
- ☐ Arthritis
- ☐ Gout
- ☐ M/S injury

Skin
- ☐ Dermatitis
- ☐ Mole(s)
- ☐ Other skin condition(s)
- ☐ Psoriasis

Neurological
- ☐ Epilepsy
- ☐ Seizures
- ☐ Severe headaches, migraines
- ☐ Stroke
- ☐ TIA

Psychiatric
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Hallucinations, delusions
- ☐ Suicidal ideation
- ☐ Suicide attempts

Endocrine
- ☐ Goiter
- ☐ Hyperlipidemia
- ☐ Hypothyroidism
- ☐ Thyroid disease
- ☐ Thyroiditis
- ☐ Type I DM
- ☐ Type II DM

Heme/Onc
- ☐ Anemia
- ☐ Cancer

Infectious
- ☐ HIV
- ☐ STDs
- ☐ Tuberculosis (dz)
- ☐ Tuberculosis (exposure)

Other:_____

_____

ALLERGIES

PLEASE LIST ANY ALLERGIES TO MEDICATION OR FOOD:

MEDICATION NAME	SYMPTOMS/REACTION

MEDICATIONS LIST CURRENT MEDICATIONS, OVER THE COUNTER, HERBS & SUPPLEMENTS:

NAME	STRENGTH/FREQUENCY	NAME	STRENGTH/FREQUENCY

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MEDICAL RECORDS-WE ASSURE THE PRIVACY AND CONFIDENTIALITY OF YOUR RECORDS. NO INFORMATION WILL BE RELEASED BY OUR OFFICE WITHOUT YOUR CONSENT TO ANY PARTIES OTHER THAN YOUR PHYSICIANS. OUR MEDICAL RECORDS DEPARTMENT HANDLES INFORMATION REQUESTS; HOWEVER THERE MAY BE A SERVICE FEE FOR COMPLETING. PLEASE TALK TO THE FRONT DESK. ALLOW 7-10 DAYS FOR RECORDS TO BE COPIED.

COST OF REPRODUCING MEDICAL RECORDS-64B8-1 0.003 1-ANY PERSON LICENSED PURSUANT TO CHAPTER 458, F.S., REQUIRED TO RELEASE COPIES OF PATIENT MEDICAL RECORDS MAY CONDITION SUCH RELEASE UPON PAYMENT BY THE REQUESTING PARTY OF THE REASONABLE COSTS OF REPRODUCING THE RECORDS. 2-REASONABLE COST OF REPRODUCING COPIES OF WRITTEN OR TYPED DOCUMENTS OR REPORTS SHALL NOT BE MORE THAN THE FOLLOWING: ***A) FOR THE FIRST 25 PAGES, THE COST SHALL BE $1.00 PER PAGE. B) FOR EACH PAGE IN EXCESS OF 25 PAGES, THE COST SHALL BE 25 CENTS.*** 3-REASONABLE COSTS OF REPRODUCING XRAYS, AND SUCH OTHER KINDS OF RECORDS SHALL BE THE ACTUAL COSTS. THE PHRASE "ACTUAL COSTS" MEANS THE COST OF THE MATERIAL AND SUPPLIES USED TO DUPLICATE THE RECORD, AS WELL AS THE LABOR COSTS AND OVERHEAD COSTS ASSOCIATED WITH SUCH DULPICATION. CREDITS(S): SPECIFIC AUTHORITY 458.309 FS. LAW IMPLEMENTED 455.674, 455.677, 458.331 (1) FS. HISTORY-NEW 11/17/87, AMENDED 5/12/88, FORMERLY 21 M-26.003, 61 F6-26.003, 59R-10.003. ALLOW 7-10 BUSINESS DAYS FOR RECORDS TO BE COPIED.

OFFICE POLICIES

SCHEDULING APPOINTMENTS

Every effort is made to keep your waiting time to a minimum. We request that you arrive 15 minutes before your scheduled appointment time. ALWAYS bring a valid I.D. and your current insurance cards to obtain services. Please bring with you a list of all prescribed and over-the-counter medications you are presently taking to each office visit. Patients who arrive late for appointments will have to be worked in between patients who have arrived on time. This may extend your wait time. The other option is to reschedule your appointment for the next opening on the physician's schedule. For AUTO and WORKMAN'S COMPENSATION APPOINTMENTS, we must have all required information before you are seen by the doctor.

SAME DAY APPOINTMENTS

If you have a medical problem that you believe requires a "same day" appointment, *please call the office as early as possible during office hours to schedule an appointment with your physician.*

CANCELLATION POLICY

Kindly give 24 hours' notice if you are unable to keep your appointment. *If you do not cancel 24 hours prior to your appointment or are a "no show", you will be subject to a $35.00 "no show" fee.* This fee is not the responsibility of your insurance company and they will not be billed.

REFERRALS FOR SPECIALITY CARE

If your insurance company requires that you obtain a referral from a primary care physician (your PCP) prior to seeing a specialist, they also require your primary care physician to conduct a medical evaluation of your medical problem and your need for specialty care. Therefore, if you believe you need to see a specialist, we ask that you make an appointment with your primary care physician in order that he or she may evaluate the problem and make a determination of need for, and nature of, the specialty referral.

SPECIAL FORMS OR LETTER REQUEST

There is a $35.00 charge for all medical forms or letters of any kind to be completed by our practice. Please allow 10 days.

AFTER HOURS ***If you have a life threatening emergency, call 911, or go to the nearest emergency room.**

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PAYMENT

Payment will be requested at the time of service for all services which are not covered or determined to be the patient's responsibility, including self-pay (no insurance), co-payments, deductibles and co-insurance depending on your coverage. *We will kindly reschedule your appointment if you are unable to pay at the time of services are rendered.* Methods of payment include cash, debit, MasterCard, Visa, Discover Card, and American Express. We also accept personal checks. If a check should bounce for non-sufficient funds, there will be a $25.00 charge to the patient.

FINANCIAL POLICY

Madison Advanced Foot & Ankle participates with most major insurance carriers. Please consult the provider list for in-network savings with your insurance company. *It is imperative that the office has your correct insurance information on file at all times. It is ultimately your responsibility to know the benefits provided under your insurance plan.* As a courtesy to our patients, we file insurance claims for those insurances with which we participate. Accounts with outstanding balances greater than 90 days will be considered in collection status. All costs associated with sending the patient to collections will be the responsibility of the Guarantor. Payment plans can be arranged by speaking with the front desk.

PRESCRIPTION REFILLS

***Please call your pharmacy regarding refills on medications at least 72 hours in advance to allow sufficient time for the pharmacy, and your physician, to receive and respond to your request before you run out of your medication.* For maintenance medications, your healthcare provider will prescribe enough refills to last until your next office visit. If you are out of refills, this is an indication of the need to schedule a follow-up appointment with your physician. YOU MUST HAVE A VALID I.D. TO OBTAIN SERVICES.**

ASSIGNMENT OF INSURANCE BENEFITS
Medicare, Supplemental and Commercial Insurance

If applicable, I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services ("CMS") and its agents and/or any supplemental insurance companies any information needed to determine benefits or the benefits payable for related services. I request that payment of authorized benefits be made to **Madison Advanced Foot & Ankle** ("The Practice") on my behalf for any services furnished me by or in The Practice, including physician services. I authorize The Practice to act as my agent to help me assure payment from Medicare and any supplemental insurance companies. As part of my treatment, The Practice may prescribe testing procedures to be performed here. I understand, and have been advised that, according to Wisconsin Law, I am under no obligation to use this facility. ***I understand that I am responsible for full payment of any charges, including non-covered services, deductibles, and/or co-payments due.*** Regarding Commercial Insurance if applicable, I authorize the release of medical information that is necessary to process claims. I understand that some, and perhaps all, of the services may be non-covered services and may not be considered medically necessary under my insurance contract. **Madison Advanced Foot & Ankle** request that payment of authorized benefits be made on my behalf to ("The Practice") for any services provided by The Practice physicians. ***I understand that I am responsible for full payment of any charges, including non-covered services, deductibles, and/or co-payments due. I further understand that I am responsible to notify this office of any pre-authorization or pre-certification required by my insurance company. It is my responsibility to ensure that an authorization is on file with The Practice prior to having my procedure performed. When applicable, I understand that I am RESPONSIBLE for full payment of all charges in the absence of an authorization.***

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Madison Advanced Foot & Ankle ("The Practice") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of The Practice. I understand that diagnosis or treatment of me by The Practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of The Practice. The Practice is not required to agree to the restrictions that I may request. However, if The Practice agrees to a restriction that I request, the restriction is binding on The Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that The Practice has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review The Practice's Notice of Privacy Practices prior to signing this document. The Practice's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of The Practice. The Notice of Privacy Practices for The Practice is also provided in our waiting room. This Notice of Privacy Practices also describes my rights and The Practice's duties with respect to my protected health information.

The Practice reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

SIGNATURE OF PATIENT/PARENT OR LEGAL GUARDIAN **DATE**

_____

PRINTED NAME