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Lower Limb Institute
Foot, Ankle, Periphral Nerve Surgery

PROVIDER: Mina Abadeer

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____ MALE FEMALE

HOME ADDRESS: _____ ZIP _____

MARITAL STATUS: MARRIED SINGLE DIVORCED OTHER

ETHNICITY: AMERICAN INDIAN ASIAN BLACK CAUCASIAN HISPANIC REFUSED UNKNOWN

SOCIAL SECURITY NO. _____

PREFERRED PHONE NO.: HOME _____ CELL _____

EMAIL ADDRESS: _____ BEST WAY TO CONTACT YOU: _____

MAY WE LEAVE MESSAGES/TEXT REGARDING OFFICE AND TESTING APPOINTMENTS ON YOUR VOICEMAIL? Yes No

HOME ADDRESS: _____

REFERRING DOCTOR: _____

OTHER REFERRING SOURCE: ADS FAMILY/FRIENDS INSURANCE NEWSPAPER INTERNET OTHER

PHARMACY: _____

NAME

CROSS STREETS

PHONE

PATIENT EMPLOYER INFORMATION

PATIENT'S EMPLOYER NAME: _____

PATIENT'S OCCUPATION: _____ WORK PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____ POLICY #: _____

INSURED'S NAME: _____ INSURED'S DOB: _____

INSURED'S ADDRESS: (If different from patient): _____

RELATIONSHIP TO PATIENT: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP _____ PHONE: _____

EXPLANATION OF PAYMENT POLICY & INSURANCE FILING PROCEDURES

I HEREBY PERMIT LOWER LIMB INSTITUTE OF NJ TO RELEASE MEDICAL INFORMATION AND NECESSARY DATA PERTINENT TO THE FILING OF INSURANCE PAPERS IN THE INTEREST OF THE PATIENT NAMED ABOVE AND THE FACILITY. I AUTHORIZE MY INSURANCE CARRIERS TO PAY BENEFITS DIRECTLY TO DR. MINA ABADDEER DPM, PC OF NJ ON ANY UNPAID SERVICES FILED ON MY BEHALF BY DR. MINA ABADDEER DPM, PC OF NJ. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT TO MINA ABADDEER DPM, PC FOR CHARGES FOR THE ABOVE PATIENT, REGARDLESS OF MY INSURANCE COVERAGE. I ALSO UNDERSTAND THAT MINA ABADDEER DPM, PC IS NOT ULTIMATELY RESPONSIBLE FOR COLLECTING MY INSURANCE OR NEGOTIATING SETTLEMENTS OF CLAIMS.

PATIENT'S NAME: _____

DATE: _____

CONSENT FOR RELEASE OF INFORMATION/RECORDS TO REFERRING DOCTOR

PATIENT'S NAME: _____ DATE: _____

I HEREBY GIVE MY PERMISSION FOR FOOT & ANKLE CENTER OF ARIZONA TO RELEASE OR DISCLOSE TO:

(Name of Doctor, Hospital, Agency, etc.)

THIS CONSENT IS SUBJECT TO REVOCATION AT ANY TIME IN THE FORM OF WRITTEN NOTICE FROM ME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON, OR WITHOUT REVOCATION, WILL EXPIRE ON _____ (THIS IS NOT TO EXCEED ONE YEAR).

SIGNATURE OF PATIENT: _____ DATE: _____

ADDITIONAL PEOPLE WHO MAY RECEIVE MY PROTECTED HEALTH INFORMATION

BESIDES THE PERSON LISTED AS MY EMERGENCY CONTACT, I AUTHORIZE THE FOLLOWING ADDITIONAL PEOPLE WHO MAY RECEIVE MY PROTECTED HEALTH INFORMATION. I UNDERSTAND I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY GIVING WRITTEN NOTIFICATION TO THIS OFFICE.

THESE PEOPLE MAY RECEIVE MY PROTECTED HEALTH INFORMATION:

NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: SPOUSE CHILD PARENT OTHER

NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: SPOUSE CHILD PARENT OTHER

SIGNATURE OF PATIENT: _____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY WHICH IS LOCATED ON THE OFFICE WEBSITE, AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOOSE) AND UNDERSTAND THE NOTICE.

PARENT OR AUTHORIZED SIGNATURE

DATE

PRINT NAME

PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing the Foot & Ankle Center of Arizona for your care. This financial policy is an important part of your care. Due to increased insurance company demands, we ask you to read and agree to the following provisions:

REFERRALS – If your insurance plan requires a referral from your primary care physician, it is **YOUR** responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not obtain your referral, you will be responsible for the visit charges in full at the time of service.

APPOINTMENTS – As a courtesy, we attempt to contact every patient to remind them of their appointment. We kindly ask you to notify us 24 hours in advance in the event you cannot keep your appointment. A \$50 fee will be incurred by you in the event of a NO-SHOW or a cancellation made less than 24 hours before your appointment time.

INSURANCE – Your insurance policy is a contract between you and the insurance company. As a courtesy, we will file your insurance claim for you. This allows the insurance company to pay the doctor's office directly.

CO-PAYMENTS & DEDUCTIBLES – Our policy is to collect your portion of the insurance designated co-payment/co-insurance/deductible payments at the time of service. Please be prepared to pay at your visit. We accept VISA, MASTERCARD, AMEX, DISCOVER, CASH, OR CHECK.

OUT OF NETWORK BENEFITS – If we do not participate with your plan but you would like to be treated in our office, we will send a courtesy bill to that carrier on your behalf. Patients are responsible for co-pays, co-insurance and deductibles at the time of the service. A paid receipt will be provided to you to submit to your insurance company. Should your insurance not pay the claim, you will be responsible with the full amount due. If you receive a payment from the insurance company directly, please forward it to our office if you have an outstanding balance.

SERVICES NOT COVERED BY YOUR INSURANCE PLAN – Services not covered by your insurance plan are your responsibility and are to be paid in full at the time services are provided.

PRIVATE PAY PATIENT – If you have no insurance coverage, full payment is expected at the time of service.

SURGERY PATIENTS – Surgical procedures might require a pre-payment of deductible and co-insurance payments if applicable. You will be informed if this applies to your surgery. Surgery Date Change/Cancellation Fee is \$250.00 after your surgical consultation.

DELINQUENT ACCOUNTS – Statements are mailed out on a monthly basis. We request that your balance is paid off within 30 days. Past due accounts are subject to collection proceedings without further notice if unpaid after 90 days. In the event your account is turned over to collections, you are responsible for all associated collection costs and late fees.

RETURNED CHECKS – Returned checks are subject to a \$25.00 fee and all future payments need to be made by cash or a valid credit/debit card.

LABORATORY FEE – Laboratories bill separately for their services. Any Lab services that are not covered by your insurance will be your responsibility.

ADDRESS AND INSURANCE CHANGES – Please let us know if you have changes in your address, phone numbers, insurance, etc. so that your information is always current in our records.

AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR - Patients under the age of 18 (minors) must be accompanied by a parent/legal guardian unless prior arrangements have been made. In the event that the accompanying adult is not the parent/legal guardian, Consent to Treat Form must be filled out. This can be found on our website. The person bringing in the child for medical treatment will be held responsible for payment at the time services are rendered.

DIVORCE/CUSTODY - Our policy is to hold the parent who brings in the child for medical treatment responsible for payment at the time of service. Our office does require documentation from the court for all legal matters that relate to your child's care; *i.e.*, custody, medical decisions, medical record access, etc.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY AND I AGREE TO THE TERMS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED IN THE EVENT MY INSURANCE DENIES PAYMENT AFTER A CLAIM HAS BEEN SUBMITTED BY MINA ABADEER DPM, PC. I UNDERSTAND THAT MY INSURANCE IS AN ARRANGMENT BETWEEN MYSELF AND MY INSURANCE COMPANY, AND THAT IT IS MY RESPONSIBILITY TO UNDERSTAND MY BENEFITS.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY:

DATE: _____

HISTORY AND INTAKE FORM

Please fill out the following confidential form for our records

PATIENT NAME: _____ DATE OF BIRTH: _____ SHOE SIZE _____

MARITAL STATUS: MARRIED SINGLE DIVORCED OTHER HEIGHT _____ WEIGHT _____

INSURANCE COMPANY: _____ POLICY # _____ PHONE: _____

CURRENT FOOT OR ANKLE PROBLEM: _____

NAME OF PRIMARY PHYSICIAN: _____ PHONE: _____

NAME OF FORMER PODIATRIST/ORTHOPEDIST: _____

WHAT CONDITIONS WERE YOU TREATED FOR? _____

MEDICAL HISTORY

<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	EPILEPSY/SEIZURES
	<input type="checkbox"/> TYPE I	<input type="checkbox"/>	EPILEPSY/SEIZURES
	<input type="checkbox"/> TYPE II	<input type="checkbox"/>	FOOT PROBLEMS
<input type="checkbox"/>	THYROID DISEASE	<input type="checkbox"/>	HIGH BLOOD PRESSURE
<input type="checkbox"/>	VASCULAR/CIRCULATORY DISEASE	<input type="checkbox"/>	HIGH CHOLESTEROL
<input type="checkbox"/>	HEART DISEASE	<input type="checkbox"/>	BLEEDING DISORDERS
<input type="checkbox"/>	STROKE	<input type="checkbox"/>	CANCER
<input type="checkbox"/>	HEART ATTACK		<input type="checkbox"/> TYPE:
<input type="checkbox"/>	GOUT	<input type="checkbox"/>	ANEMIA/BLOOD DISEASE
<input type="checkbox"/>	LIVER DISEASE	<input type="checkbox"/>	ASTHMA
<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	BRONCHITIS
<input type="checkbox"/>	IMMUNE DISEASE (HIV, AIDS)	<input type="checkbox"/>	ACID REFLUX
<input type="checkbox"/>	DEPRESSION	<input type="checkbox"/>	STOMACH ULCER
<input type="checkbox"/>	ANXIETY		

MEDICATIONS

(Please include dosage and frequency of each)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

ALLERGIES

(Penicillin, Novocaine, Tape, etc.)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

