PHOENIX FOOT AND ANKLE INSTITUTE

New Patient Questionnaire

Patient Information

First Name: _____ Last Name: _____ Date of Birth: _____

Age: _____ Gender: _____ Ethnicity: _____ Race: _____

Mailing Address:_____ City:_____ State: _____

Zip Code: _____ Home Phone: _____ Height: _____ Weight: _____ Recent Blood Pressure: _____/_____

Cell Phone : _____ Email:_____ SSN:_____-_____-_____

Pharmacy: _____ Address: _____ Zip:_____
Preferred Method of contact from our office: [ ] Email [ ] Home Phone [ ] Cell Phone
Are you the primary policy holder of your insurance? [ ] Yes [ ] No
If no, what's the primary policy holder's name? _____

And Date of Birth:_____ Relationship of the policy holder to you: _____ SSN:_____

Employment Information

Employer's Name: _____
Employer's Address: _____

Primary Care Physician: _____ Phone: _____
Would you like us to send medical records to this physician? [ ] Yes [ ] No
How did you hear about **Phoenix Foot & Ankle Institute**? _____Referred By:_____
Facebook: _____ Website: _____ Insurance: _____Word of Mouth: _____Law Firm:_____

Emergency Contact:_____Phone:_____Relationship:_____
I am granting full permission for all medical information including medical records, imaging, surgical information, appointment information to be released to the person(s) listed below:

1._____ 2._____3._____

Financial Information

[ ] Self Pay [ ] Insurance [ ] Medicare [ ] Worker's Compensation [ ]Lien

Primary Insurance Carrier: _____ ID: _____

Group #: _____ Phone #: _____

Secondary Insurance Carrier: _____ ID: _____

Group #: _____ Phone #: _____

Authorization for Release of Medical Information:
I hereby authorize **Phoenix Foot & Ankle Institute** to furnish my medical records consisting of, but not limited to consultation notes, diagnostic test results, progress notes, operative reports and other medical information to the above stated office. This release is in effect for one year from the date noted.

_____ _____
Signature of patient or patient's parent/ legal guardian **Date**

Reason for Today's Visit

Have you seen Dr. McAlister in the past? [ ] Yes [ ] No
Please describe the foot/ ankle issue that brings you in today: [ ] Left [ ] Right _____

Duration of problem? _____ Have you had this problem in the past? [ ] Yes [ ] No

How would you rate your pain on a scale of 0 (no pain) – 10 (worst pain)? _____

What treatment have you attempted? _____

Does anything make it feel better? _____

Past Medical History

Are you Diabetic? [ ] Yes [ ] No If yes, how long _____ What type? _____

Most Recent A1C? _____ Date:_____
Do you have any of the following? **[ ] No Past Medical History**
[ ] High Blood Pressure [ ] High Cholesterol [ ] Cancer: _____ [ ] Heart Attack [ ] Stroke
[ ] Rheumatoid Arthritis [ ] Kidney Disease [ ] Heart Failure [ ] Stomach Bleeds [ ] Blood Clots
[ ] Other: _____

Past Surgical History

Please list any past surgical procedures you have had. **[ ] No Past Surgical History**

1._____ Year: _____ 4. _____ Year: _____
2._____ Year: _____ 5. _____ Year: _____
3._____ Year: _____ 6. _____ Year: _____

Current Medication(s)

Please list any medications you are currently taking at this time:
(Including over the counter medications and supplements) **[ ] No Current Medications**

1._____ Dose: _____ 4. _____ Dose: _____
2._____ Dose: _____ 5. _____ Dose: _____
3._____ Dose: _____ 6. _____ Dose: _____

Allergies

Please List any allergies to medications, latex, or food: **[ ] No Known Allergies**

1._____ Reaction: _____ 3. _____ Reaction: _____
2._____ Reaction: _____ 4. _____ Reaction: _____

Social History

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Current Employment Status:
[ ] Full-time [ ] Part- time [ ] Student [ ] Retired [ ] Disabled [ ] Unemployed

Occupation: _____
Do you smoke cigarettes?

[ ] Never [ ] Current Smoker, ____ day for _____ years [ ] Past Use, quit _____ years ago
Do you drink alcohol? [ ] Yes, how much? _____ [ ] No
Do you use recreational drugs? [ ] Yes, what and how much? _____ [ ] No

Family Health History

[ ] Diabetes: Relationship: _____
[ ] High Blood Pressure: Relationship_____
[ ] High Cholesterol: Relationship: _____
[ ] Rheumatoid Arthritis: Relationship: _____
[ ] Cancer: Relationship: _____
[ ] Stroke: Relationship: _____
[ ] Other: Relationship: _____
[ ] None or Unknown

Review of Systems

General: [ ] Loss of appetite, [ ] Recent weight loss, [ ] Fatigue, [ ] Fever or chills, [ ] Weakness
Respiratory: [ ] Shortness of breath, [ ] coughing, [ ] coughing blood, [ ] difficulty breathing, [ ] wheezing
Cardiovascular: [ ] chest pain, [ ] tightness, [ ] palpitations, [ ] swelling, [ ] difficulty breathing lying
Head/Eyes/Ears/Nose/Throat: [ ] Headaches, [ ] neck pain, [ ] decreased hearing, [ ] ringing in ears, [ ] vision changes, [ ] Glaucoma, [ ] cataracts, [ ] blurry/ double vision, [ ] itching nose, [ ] sinus pain, [ ] nosebleeds, [ ] dentures, [ ] mouth sores/bleeding, [ ] sore throat, [ ] dry mouth
Neurological: [ ] Dizziness, [ ] fainting, [ ] seizures, [ ] numbness, [ ] tingling
Gastrointestinal: [ ] Nausea, [ ] Vomiting, [ ] Constipation, [ ] diarrhea,[ ] difficulty swallowing,[ ] heartburn
Endocrine: [ ] Sweating, [ ] Frequent urination, [ ] Excessive thirst, [ ] change in appetite
Psychiatric: [ ] nervousness, [ ] stress, [ ] depression, [ ] memory loss
Skin: [ ] Rashes, [ ] Itching, [ ] dryness, [ ] Hair and nail changes, [ ] skin color changes
Kidney/Bladder/ Urine: [ ] Frequency, [ ] urgency, [ ] burning or pain, [ ] blood in urine, [ ] incontinence
Musculoskeletal: [ ] Muscle and joint pain, [ ] stiffness, [ ] back pain, [ ] swelling of joints

_____ _____
Signature of patient or patient's parent/ legal guardian **Date**

Financial Acknowledgement and Agreement – New Patient Forms

Thank you for choosing the Phoenix Foot and Ankle Institute! The Financial and Office policy is an important part of your care. Due to increased insurance company demands, we ask you to read and agree to the following Phoenix Foot and Ankle Institute policies.

Self-Pay Patients: If you have no insurance coverage, full payment is expected at the time of service. Please contact an office team member for fees.

Commercial Insurance: As a courtesy, Phoenix Foot and Ankle Institute will file your claim to your insurance company; however, at the time of service you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles and non-covered services or items received. The co-pay **CANNOT** be waived by our practice, as it is a requirement placed on us by your insurance carrier. We strive to be as accurate as possible in calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact. You may receive a statement from our office for any balance due. For your convenience, we accept cash, checks, and most major credit cards.

Knowing and understanding your insurance benefits is your responsibility.

If you have any "Out of Network Benefits" with a plan we are not contracted with, we will bill your insurance as a courtesy. Any patient responsibility will be billed to the guarantor on file. Please contact your insurance company with any questions you may have regarding your coverage. I also authorize the release of any medical records or other information necessary to process a claim. To submit a claim to your insurance carrier, there must be complete patient and insurance information on file. It is your responsibility to notify Phoenix Foot and Ankle Institute if there is a change to your insurance coverage, residence or phone number.

_____ _____

Signature of Responsible Party **Date**

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to Jeffrey E McAlister, PLLC dba Phoenix Foot and Ankle Institute. I also authorize the release of any medical or other information necessary to process a claim. To submit a claim to your insurance carrier, there must be complete patient and insurance information on file.

_____ _____

Signature of Responsible Party **Date**

HIPAA Acknowledgment

Our Centers Notice of Privacy Policies provide information about how we may use and disclose protected health information. You have the right to review our Notice before signing this consent. The terms of our Notice may change, and you may obtain a revised copy by contacting our office. By signing this acknowledgement, I understand and agree with the contents of the notice.

_____ _____

Signature of Patient **Date**

If not signed by the patient, please indicate relationship to patient: _____

Signature: _____ **Date**:_____

Financial and Office Policy

Return Check Fees: There is a **$25** fee for any checks returned by the bank. Non-sufficient funds checks must be paid in full with certified funds (money order, credit cards, or cash). You will no longer be able to make payments on your account with a check instead, future payments will need to be cash, credit card or money order only.
Past Due Accounts: We will send three (3) statements, prior to sending a past due notice. If no payment is then received, a final Pre- collection Courtesy Notice will be sent. After 30 days of no response, your account will be sent to a Collections agency.
Lateness: If you are late for our appointment time, please call to inform the staff. They will review the schedule to determine if the appointment will need to be rescheduled to another day or work an appointment behind other scheduled appointments. **After the 2nd late show a $50 fee will be applied to your account**.
No Shows/ Cancellations: A missed appointment leaves an open appointment that could have been used by a patient in need of medical care. A no-show appointment occurs when a parents or legal guardian fails to give adequate notice that the appointment cannot be kept. The parent or legal guardian's failure to cancel or reschedule an appointment by 9:00am the day of the scheduled appointment will result in a no-show. If two (2) no- shows are incurred during a calendar year (January – December) a **$50 fee** will be applied to your account.
Appointments: All New patients need to arrive 15 minutes prior to their appointment, and all Established patients need to arrive 15 minutes prior to their appointment.
Divorce/ Custody: We cannot and will not become involved with parental billing disputes in divorce and/or custody cases. Our policy is to hold the parent who brings the child in for medical treatment responsible for payment at the time of service
Laboratory Fees: You will receive a separate laboratory fee for outside lab services. Any lab services that are not covered by your insurance will be your responsibility. It is your responsibility to go to a contracted lab. Phoenix Foot and Ankle Institute is not affiliated with any labs.
Surgical Cancellation Fees: Our team works very hard to appropriately get you set up for surgery, which involves insurance verification, hospital scheduling, and assistance with pre-operative clearance. If you knowingly cancel your surgery within one week from the surgery date, there is a **$250 fee**. If you knowingly cancel your surgery on the day of surgery, there is a **$500** fee.

Medical Records Policy

Hard Copy Medical Records: Any printed medical records that are less than 20 pages are free. Medical records that are 21-41 pages are 25 cents per page, and medical records pertaining more than 50 pages are $10.
Short Term Disability Form: There is a $25 charge for the completion of FMLA paperwork.
USB Medical Records: Any medical records requested on a USB (up to 2 GB) will be $15. If more than 2GB of medical records an additional fee will be applied.
Xrays requested on a USB will have a **$10 fee.**

I have read and understand Phoenix Foot and Ankle Institute Financial and Office Policies and agree by its 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 Phoenix Foot and Ankle Institute.

Patient Printed Name: _____

If not the patient, please print your relationship to the patient and your name:_____

Your Signature: _____ Date: _____

Consent to Treat Patient's under 18 years of age

Date: _____
(Valid for 1 Calendar year)

Consent from Parents or Guardians for Authorized Persons:

As the parent or guardian of _____, I am granting permission for the below listed person(s) to bring my child in for treatment and/ or care

I am granting full permissions, meaning the below listed person(s) will be allowed to agree to:

- **Treatments**
- **Procedures**
- **Injections**
- **Referrals**
- **Medical Records**
- **Pre-Surgical Consent**
- **All medical history pertaining to my child**

_____ **Initials**

Please list person(s) here	**Relationship**
_____	_____
_____	_____
_____	_____

Consent to Leave Voicemail

I am granting permission for Phoenix Foot and Ankle Institute to leave phone messages regarding my child's medical health to the number(s) provided on the registration form.

_____ Initials

_____ _____
Parent/ Guardian Signature Date