

# PREMIER FOOT & ANKLE

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_M\_\_\_F

Address: \_\_\_\_\_

Street Apt. No City State Zip

Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell #: \_\_\_\_\_

Email: \_\_\_\_\_ \*\* Circle preferred method for reminder calls.

Emergency Contact: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Employed: \_\_\_Y\_\_\_N Occupation: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Marital Status (circle): Married Single Divorced Widowed Partner

**PRIMARY CARE PHYSICIAN** \*\*Must be a doctor of Family Medicine, Primary Care, Internal Medicine, Endocrinology

Name: \_\_\_\_\_

Primary Physician Phone: \_\_\_\_\_ Date Last Seen: \_\_\_\_\_

*PLEASE NOTE: Medicare related insurances require that a Primary Care Physician be listed for certain services to be paid*

## HOW DID YOU HEAR ABOUT US? (circle)

Physician Internet Insurance Friend Family Other \_\_\_\_\_

## INSURANCE INFORMATION

**PRIMARY INSURANCE NAME:** \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Policy Holders Date of Birth: \_\_\_\_\_ Patient Relationship to Policy Holder: \_\_\_\_\_

**SECONDARY INSURANCE NAME:** \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Policy Holders Date of Birth: \_\_\_\_\_ Patient Relationship to Policy Holder: \_\_\_\_\_

## EXPLANATION OF PAYMENT POLICY & PRIVACY POLICY

I hereby authorize Premier Foot & Ankle to release medical information pertinent to the filing of insurance claims for me. I authorize my insurance carrier to pay benefits directly to Premier Foot & Ankle on any unpaid services filed on my behalf. I understand that I AM RESPONSIBLE for payment to Premier Foot & Ankle for charges for the above patient regardless of my insurance coverage. I also understand that Premier Foot & Ankle is not ultimately responsible for collecting my insurance or negotiating settlements of claims. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have had the opportunity to read and understand the Notice. I also hereby give Premier Foot & Ankle permission to diagnose and administer treatment for my foot and/or ankle condition and authorize any release of information obtained during the course of my treatment.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# PREMIER FOOT & ANKLE

**Patients Name:** \_\_\_\_\_ **Shoe Size:** \_\_\_\_\_

**Reason for your visit:** \_\_\_\_\_ **Pain Level:** \_\_\_\_\_

**Alcohol Intake:** \_\_\_\_\_ **Caffeine Intake:** \_\_\_\_\_

**Smoker:** \_\_\_\_\_ pack(s)/day X \_\_\_\_\_ years **Previous smoker:** YES NO How much/long: \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Constitutional:** Are you currently experiencing (please circle): Nausea Vomiting Fever Chills Night Sweats

**Date of Last Flu Vaccine:** \_\_\_\_\_ **Pneumonia Vaccine:** \_\_\_\_\_ **COVID Vaccine:** \_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_ **Pharmacy Phone:** \_\_\_\_\_

**Pharmacy Location and/or Address:** \_\_\_\_\_

**Medications:** List current medications & dosage: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Past Medical History:** If you have or have had any of the following conditions, please Check ALL that apply.

<input type="checkbox"/> Athlete's Foot	<input type="checkbox"/> Dementia	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Osteopenia
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Diabetes I	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Diabetes II	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Dialysis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Peripheral Arterial Disease (PAD)
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Eczema	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Peripheral Vascular Disease (PVD)
<input type="checkbox"/> COPD	<input type="checkbox"/> Endocrine Disorder	<input type="checkbox"/> Immune Disease	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Fibroid Tumors	<input type="checkbox"/> Lupus	<input type="checkbox"/> Seizures
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> GERD	<input type="checkbox"/> Lymphedema	<input type="checkbox"/> Stroke
<input type="checkbox"/> Currently Pregnant	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Nail Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Deep Vein Thrombosis (DVT)	<input type="checkbox"/> Gout	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> OTHER:

**Allergies:** Yes No If yes, please list: \_\_\_\_\_

\_\_\_\_\_

**Family History:** Please circle any medical conditions that run in your family and write which member(s) affected.

Diabetes \_\_\_\_\_ Gout \_\_\_\_\_ Heart Disease \_\_\_\_\_ Circulation Problems \_\_\_\_\_ High Blood Pressure \_\_\_\_\_

High Cholesterol \_\_\_\_\_ Other \_\_\_\_\_

**Surgeries:** List all surgeries you have had. Begin with the most recent. Please give the year.

\_\_\_\_\_  
\_\_\_\_\_

If **diabetic**, who handles your diabetes? \_\_\_\_\_ Phone #: \_\_\_\_\_

Last A1C? \_\_\_\_\_ Date Performed: \_\_\_\_\_ Performed by: \_\_\_\_\_

## **PREMIER FOOT & ANKLE**

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctors. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, you will receive a bill.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be “not covered,” or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/ referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery or at the time of your Pre-op appointment.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office.
- Patients who are 90 days past due on their balance will be sent to collections unless a payment plan has been put into place.
- There is a service fee of \$25.00 for all returned checks. Your insurance company does not cover this fee.
- In fairness to all our patients, we understand that emergencies occur, but repeated no shows or cancellations with less than 24 hours’ notice will result in a fee of \$25.00. You might be asked to pay before you are seen by the doctor.
- Patients who come to office fifteen minutes later than scheduled appointment might be asked to reschedule.

Signature of Patient/ Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Patient/ Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_



## HIPAA COMPLIANCE PATIENT CONSENT FORM

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. The terms of this notice may change. If so, you will be notified at your next visit to update your signature and date.

By signing this form, you consent to our use and disclosure of your protected healthcare information according to the indications below.

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- This privacy policy may be changed by the practice, when necessary, as required or allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- This privacy policy will stay in effect until the time that it is revoked by the patient or changed as required by law.

### PLEASE INDICATE YOUR PREFERENCES REGARDING YOUR PERSONAL HEALTHCARE INFORMATION:

Health notifications:     E-mail     Phone     Text message  
Auto Appointment Reminders:     E-mail     Phone     Text message  
Practice Announcements:     E-mail     Phone     Text message  
Billing information:     E-mail     Phone     Text message

Please indicate the phone number and/or e-mail you would like to use below:

\_\_\_\_\_

May we discuss your medical condition with a family member?     Yes     No

If YES, please list the name of the members allowed:

\_\_\_\_\_ Relationship to patient \_\_\_\_\_

\_\_\_\_\_ Relationship to patient \_\_\_\_\_

I consent to have my medical records shared with other Premier Foot & Ankle/ Stride Healthcare providers.

Yes     No - Only upon my request

I consent to have my medical records shared with my care providers outside the Stride Healthcare network.

Yes     No - Only upon my request

This consent was signed by: \_\_\_\_\_  
(PRINTED NAME PLEASE)

Patient or Guardian Signature: \_\_\_\_\_ DATE: \_\_\_\_\_