PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle:_____ Suffix: _____

Date of Birth: _____ Age: _____ Marital Status: _____ Gender:_____

Mailing Address:_____ City:_____ State: ____ Zip Code:_____

Email Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Preferred method of contact: Home phone / Cell Phone / Email Consent to receive text: Yes / No

How did you hear about us? _____

Primary Care Physician: _____ Phone number:_____

Pharmacy Name: _____ Address/Cross Streets:_____

Emergency Contact: _____ Phone: _____ Relationship: _____

I am giving 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. _____

Reason for today's visit: _____

Did the problem result from an injury: Yes / No If yes: Injury Date?_____

Was the injury due to a: Work Injury / Car Accident / Other _____

How long have you had the condition? _____ Rate your pain on a scale of 1-10: _____

Have you seen another physician for this problem? Yes / No If yes, who? _____

What **symptoms** are you experiencing? Is it Constant or Occasional?

□ Aching	□ Stabbing	□ Electrical	□ Sharp	□ Dull	□ Spasmodic	□ Shooting
□ Throbbing	□ Night Pain	□ Burning	□ Instability	□ Popping	□ Locking	□ Swelling
□ Weakness	□ Tingling	□ Stiffness	□ Sharp	□ Other:		

What, if anything, makes your symptoms **better**? _____

What, if anything, makes your symptoms **worse**? _____

MEDICAL HISTORY

Height: _____ Weight: _____ Recent Blood Pressure: _____/_____

Are you Diabetic? Yes/No If yes, how long? _____ Type? _____ Most Recent A1C: _____

MEDICAL CONDITIONS: Please list all current and/or previous medical conditions.

_____

_____

MEDICATIONS: Please list all medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medication, aspirin, and any other over-the-counter medications.

Medication	Dosage	Frequency

ALLERGIES: Please list all allergies: _____ □No Known Drug Allergies

PAST SURGICAL HISTORY: Please list all previous surgical procedures: _____

_____

SOCIAL HISTORY

Tobacco Use: □ Yes □ No Type: _____ Duration:_____ Quit Date: _____

Alcohol Use: □ Yes □ No Frequency: _____

Recreational Drug Use: □ Yes □ No Type: _____ Frequency: _____

Patient Printed Name: _____ Patient Date of Birth: _____

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

Your signature: _____ Date:_____

Thank you for choosing AZ Choice Foot and Ankle! Our Financial and Office policies are an important part of your care. Due to increased insurance company demands, we ask that you read and agree to the following AZ Choice Foot and Ankle policies.

Financial and Office Policy

Lateness: If you are late for your appointment time, please call to inform the staff. They will review the schedule to determine if the appointment will need to be rescheduled for another day.

No Shows/ Cancellations: A missed appointments leaves an open appointment that could have been used by a patient in need of medical care. A no-show appointment occurs when a patient or legal guardian fails to give adequate notice that the appointment cannot be kept. The patient or legal guardian failure to cancel or reschedule an appointment by noon the day before of the scheduled appointment will result in a no-show. If two no-shows are incurred during a calendar year (January - December) a **$50 fee** will be applied to your account.

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 responsible for payment at the time of service.

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.

Payment Plans: We offer zero interest payment plans, starting as low as $50 a month with a down payment of $50 on select procedures and products.

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 cash, credit card or money order only.

Laboratory Fees: You will receive a separate laboratory fee for outside lab services that are not covered by your insurance will be your responsibility. It is your responsibility to go and contracted lab. AZ Choice Foot and Ankle 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**.

I have read and understand AZ Choice Foot and Ankle Financial and Office Policy 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 AZ Choice Foot and Ankle.

Patient Printed Name: _____ Patient Date of Birth: _____

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

Your signature: _____ Date: _____

Updated 08/10/2021

Medical Records Policy

Hard Copy Medical Records: Any printed medical records that are less than 20 pages are free. Medical records that are more than 20 pages will be $0.25 per page up to $10.

Short Term Disability Form: There is a $25 charge for the completion of FMLA paperwork.

Financial Acknowledgment and Agreement

Self-Pay Patients: If you have no insurance, full payment or the setup of a payment plan is expected at the time of service. Please contact our office for fees.

Commercial Insurance: As a courtesy, AZ Choice Foot and Ankle 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.

Out of Network Benefits: 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.

Knowing and understanding your insurance benefits is your responsibility!

I have read and understand AZ Choice Foot and Ankle Medical Records Policy and Financial Acknowledgment and Agreement 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 AZ Choice Foot and Ankle. I also authorize the release of any medical records or other information necessary to process a claim.

Patient Printed Name: _____ Patient Date of Birth: _____

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

Your signature: _____ Date:_____

HIPAA Acknowledgment

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

Patient Printed Name: _____ Patient Date of Birth: _____

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

Your signature: _____ Date:_____

Updated 08/10/2021

Consent to Treat Patient's Under 18 Years of Age

Date: _____

(Valid for 1 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 permission, meaning the below listed person(s) will be allowed to agree to:

(Initial each line item)

_____ Treatments

_____ Procedures

_____ Injections

_____ Referrals

_____ Medical Records

_____ Pre-Surgical Consent

_____ All medical history pertaining to my child

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

Consent to Leave Voicemails

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

_____ Initials

_____ _____

Parent/Guardian Signature Date