Foot & Ankle Institute of Iowa

3613 Beaver Avenue Des Moines, Iowa 50310
Phone: 515.223.5219 **Fax:** 515.223.9344
E-mail: fai@mydoctorrudy.com

Name: _____Today's Date: _____
First Middle Last

Home Address:_____

City: _____State: _____ Zip: _____

Home Telephone: ( ) _____ Cell Telephone: ( )_____

Birthdate: _____ Age: _____

Are you: (circle one) single married widowed divorced

Email Address: _____
May we send information to your email? Yes No

Occupation: _____SSN:_____
Employer:_____ Years There: _____
Employer's Address:_____ City: _____
State: _____Zip: _____Work Phone: ( ) _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____Relationship to Patient: _____
Home Address:_____City:_____
State: _____ Zip: _____
Telephone: ( ) _____Birthdate: _____Age:_____
Occupation: _____ SSN:_____
Employer: _____Years There: _____
Employer's Address:_____ City: _____
State: _____Zip: _____Work Phone: ( ) _____

Name of Spouse/Partner/Guardian:_____Birthdate:_____
Age: _____Occupation: _____ SSN: _____
Employer: _____ Years There: _____
Employer's Address:_____ City: _____

State: _____Zip: _____Work Phone: ( ) _____

Patient Name: _____

In case of emergency, contact: _____
Relationship to you: _____
Home Phone: ( ) _____ Work Phone: ( )_____

How did you learn about our practice?

- Insurance Co. (which co.) _____
- Internet or Website (e.g., Google, Bing, etc.)_____
- Physician _____
- Friend/Family _____
- Phone Book (which one) _____
- Other _____

May we contact you at work? Yes No

May we leave a message for you at work? Yes No

Can we leave a voice mail message for you with the patient only? Yes No

Can we leave a voice mail message for you with your spouse/partner/guardian?
Yes No

Can we leave a voice mail message for you with anyone answering the phone ?
Yes No

Any other information you feel that we should know about? _____
_____
_____
_____
_____
_____
_____
_____

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INSURANCE INFORMATION

Patient's Name:_____ Today's Date:_____
First Middle Last

[Primary Insurance]
Name of Insurance Company:_____
Address: _____
City: _____State: _____Zip: _____
Insured's Name:_____
Group Number: _____Policy ID Number: _____

[Secondary Insurance]
Name of Insurance Company: _____
Address: _____
City: _____State: _____Zip: _____
Insured's Name:_____
Group Number: _____Policy ID Number: _____

Did your injury happen on the job? Yes No
If yes, on what date did the injury occur? (if applicable) _____
Did you report the accident to your employer? Yes No

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. ***Please remember that you are responsible for all deductible, copay, and non-covered service amounts.*** See our complete financial policy for details.

Method of Payment for Today's Visit: ___Cash ___Check ___Visa/MC

Insurance Agreement:

I hereby name the Doctor and/or medical practice given below, hereafter referred to as doctor, as my assignee. I instruct my health care benefits plans provider, hereafter referred to as the

Plan, to pay the Doctor directly for all professional and medical services provided. Payment should be made by means of electronic funds transfer or by checks made payable and mailed directly to the Doctor.

Rudolph La Fontant, DPM, 3613 Beaver Avenue Des Moines, IA 50310

Or if my current policy prohibits payment directly to doctors, then I hereby instruct and direct the Plan to make all checks payable to me and mail the payments to me in care of the Doctor as given directly above.

This is a direct assignment of my rights and benefits under this policy.

I grant the Doctor a limited Power of Attorney to sign my name in order to deposit and negotiate any payment received from the Plan and apply the funds received toward my outstanding balance. These payments will not exceed my indebtedness to the above –designated Doctor. I agree to promptly pay any remaining balance due on all professional and medical service charges over and above payments) from the Plan. This assignment shall remain in effect until cancelled in writing by the Doctor.

A photo copy of this agreement, or an electronic facsimile thereof, shall be considered effective as the original.

I understand that personal information about me will be needed by the Doctor and the Plan to determine and communicate what services or benefits are covered by the Plan, and to submit or process a claim for payment on services rendered, I give the Doctor, the Plan, the Centers for Medicare and Medicaid services their agents and any other holder of information about me, authorization to release and/or exchange medical billing, and collection information.

The Responsible Party who signature appears below agrees to the following:

The Doctor, Associate Doctor, and staff of the Medical Practice, named on this form and hereafter referred to as Doctor, are authorized, to medically treat the patient named on this form.

Doctor if authorized to collect, use, and exchange individually identifiable health information consisting of the patient's past, present, and future medical information and other personal information to treat the patient, communicate with the patient's other healthcare providers, seek payment, carry out necessary business functions and mandated government reporting requirements. These situations and others, as well as your rights regarding the information are explained in our separate Notice of Privacy Practices Provided to you.

The Responsible Party agrees to pay for all fees and charges for supplies, services, and treatment that are incurred by the patient per the terms of this agreement and authorize Doctor or agents thereof to make credit investigations, including employment verifications. All charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date. The Responsible Party remains financially responsible for the patient until the Doctor receives their notification in writing to the contrary.

Not all services and/or fees are covered or paid by the Responsible Party's health plan. Thereof, the Responsible Party agrees to pay for all deductibles, co-payments, non-covered services and any portion of covered services not paid in full by the Plan and understands that such payments are due at the time of service or immediately upon presentation of the bill.

All proceeds from the Plan are assigned to the Doctor where applicable. Payments to Doctor may not be withheld, delayed, or excused for any reason, including the outcome of the medical treatment, liens, lawsuits, and coverage determination by the Plan or their processing of claims, the financial insolvency of the Plan, and/or their contracted intermediaries and medical groups.

If any account balance is not paid in full within 60 days, the entire account balance will be subject to a monthly finance charge of 1.5% (APR 18%). These rates and charges are subject to change upon written notice 30 days in advance of changes.

If any account balance should remain unpaid for 60 days and Doctor refers the account to a collection agency or attorney for collection, Responsible Party agrees to pay the costs of collection and that such fees and costs may be added to the account balance. In a legal action between the parties in this agreement to collect an unpaid balance due for medical services rendered, the prevailing party shall be entitled to recover reasonable attorney's fees and costs.

The Responsible Party acknowledges receipt of Doctor's office policy that includes the terms of this Financial Agreement, Insurance Agreement, and authorization for treatment and information release. This form together with the Doctor's office policy contains the entire and only agreements between the parties. There are no other agreements, provisions, representations, or warranties, expressed or implied. The provisions of these agreements shall not be modified except for an instrument in writing assigned by the parties hereto.

I authorize the release of any medical information necessary to process my claim.

Signed:_____
(Patient or responsible party)

I authorize payment of medical and surgical benefits to Foot & Ankle Institute of Iowa.

Signed:_____
(Patient or responsible party)