Chambers Foot & Ankle

Patient Information

Patient's Name:_______________________________ Today's Date:______________

Date of Birth:_________________ Age:_______ Sex: Male ______ Female______

Social Security Number:____

Address:____

(Street) (City) (State) (Zip Code)

Home Phone:________________________ Cell Phone:_________________________

Work Phone:___________________ Patient's Occupation:_____________________

Email Address:____

Primary Care Provider:____

Preferred Pharmacy:____

Sports/Physical Activity:____

How Did You Hear About Us/Who Referred You?__________________________

Out of State Address:____

Months you are gone from Arizona: From________________ To________________

Responsible Party Information

(If self leave blank)

Responsible Party's Name:___________________________ DOB:______________

Address:____

(Street) (City) (State) (Zip Code)

Home Phone:________________________ Cell Phone:_________________________

Work Phone:___________________ Party's Occupation:_______________________

ASSIGNMENT OF BENEFITS

I authorize the release of information necessary to process this claim and hereby assign my insurance benefits be paid directly to Thomas J. Chambers DPM, and Chambers Foot and Ankle LLC. I acknowledge financial responsibility for services, which are not covered by my insurance company.

Signature: _______________________________________ Date: ___________

I authorize Chambers Foot and Ankle LLC to send me appointment reminders to:

☐ Email:_______________________________

☐ Text:________________________________

Signature: _______________________________________ Date: ___________

Patient's Name:______________________________ Date of Birth:____________

Podiatric History

Chief Complaint (Circle and fill in the blank)

What is the nature of the pain? *Sharp*, *Dull*, *Achy*, *Throbbing*, *Tingling*, *Shooting*?

Where is your pain located?____

How Long ago did your pain start?_______________________________________

Did your pain come on *suddenly* or *gradually*? Was there an injury? *YES* or *NO*

Describe Injury:____

Is your pain getting: *Better*, *Worse*, or *Staying the Same*

What makes your pain better?____

What makes your pain worse?____

Rate your pain: (no pain) 0 2 3 4 5 6 7 8 9 10 (extreme pain)

Review of Systems

(Circle all that apply)

Constitutional:

Chills, Fever, Nausea, Vomiting, Weight loss, Decline in Health, Weakness, Fatigue, Weight gain.

Cardiovascular:

Chest pain, Hair loss on legs, Swelling of legs, Varicose Veins, Extremities Cool, Extremities Discolored, Leg Pain When Walking, Ulcers on legs.

Skin:

Dryness, Itching, Nail Appearance changes, Toe nail pain, Skin Color changes, Eczema, Rashes.

Neurological:

Tingling, Burning, Numbness, Unsteady Gait, Loss of Balance.

Musculoskeletal:

Muscle Cramps, Restricted Motion, Joint Pain, Back Pain, Deformities, Joint Stiffness.

Medications: None ☐

____

____

____

Allergies to Medication: None ☐

____

____

____

Medical History (Circle all that apply)

None ☐ Other:______________________________

Anxiety	Dementia	GERD	Hypothyroidism
Arthritis	Depression	Glaucoma	Migraine
Asthma	Dermatitis	Gout	Pneumonia
Back Problems	Diabetes, Type I	Headache	Prostate Problems
CHF	Diabetes, Type II	Hepatitis	Rheumatoid Arthritis
COPD	Dialysis	Heart Disease	Renal Disease
Cancer	Epilepsy	HIV	Stroke
Cholesterol High	Fibromyalgia	Hypertension	Vascular Disease

Social History (Circle or fill in the blank)

Tobacco: Never Smoked
Current Smoker: Daily usage _______ pack/day, # of years_______
Former Smoker: Last used_________

Alcohol: None____, daily #____, weekly #____, monthly #____, other_______

Patient’s Name:______________________________ Date of Birth:____________

Family Medical History None ☐

____

____

____

Surgical History None ☐

____

____

____

Height:_____ft _____inches
Weight:___________lbs

If you are **diabetic**, how many years have you been diagnosed?___________
Most recent HbA1c:_________ Last fasting blood sugar?___________

Additional Comments:____

____

____

____

I authorize the release of medical information / test results to the following person(s) other than myself.

______________________________________ ___________________________

Name Relationship

_____________________________________ ___________________________

Name Relationship

____ ______________________

Signature Date

I authorize Chambers Foot and Ankle LLC to leave information / test results on my voicemail and / or answering machine at the following contact numbers.

Home:_________________ Cell:_________________ Work:_________________

____

Patient Name (Please Print)

____ ____________________

Signature Date

____ ______________________

Parent or Authorized Representative (if applicable) Signature

Chambers Foot and Ankle - 5520 E Main Street, Suite 2 - Mesa, AZ 85205
Phone (480) 985-3730 - Fax (480) 985-4532

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice. (Ask front desk for copy)

____

Patient Name (Please Print)

____________________________________ ________________

Signature Date

_________________________________ __________________

Parent or Authorized Representative (if applicable) Signature

PATIENT FINANCIAL OBLIGATION AGREEMENT

- I / WE, THE UNDERSIGNED, AUTHORIZE THE DOCTOR(S) AND STAFF OF THE MEDICAL PRACTICE LISTED ABOVE TO TREAT THE PATIENT NAMED ON THIS FORM AND AGREE TO PAY ALL FEES AND CHARGES FOR SUCH TREATMENT.
- I / WE AGREE TO PAY ALL CHARGES FOR MYSELF AND MEMBERS OF MY FAMILY PER THE TERMS OF THIS AGREEMENT. CHARGES SHOWN ON THE BILLING STATEMENTS ARE AGREED TO BE CORRECT AND REASONABLE UNLESS DISPUTED IN WRITING WITHIN 30 DAYS OF THE BILLING DATE.
- I / WE ACKNOWLEDGE THAT SHOULD ANY BALANCE REMAIN UNPAID BY MY HEALTHCARE PLAN AFTER 90 DAYS FROM THE DATE THAT SERVICES WERE PROVIDED, THE ENTIRE BALANCE WILL BE BILLED TO ME. IF ANY PATIENT BALANCE IS NOT PAID IN FULL WITHIN 30 DAYS OF THE ORIGINAL PATIENT STATEMENT DATE, THE ENTIRE BALANCE WILL BE SUBJECT TO A 1.5% MONTHLY SERVICE CHARGE.
- I / WE AGREE THAT IN THE EVENT THAT LEGAL ACTION BECOMES NECESSARY TO COLLECT AN UNPAID BALANCE DUE FOR SERVICES RENDERED TO ME OR MY LEGAL CHARGE, I AM RESPONSIBLE FOR ANY AND ALL ATTORNEY'S FEES AND COURT COSTS INCURRED BY THE ABOVE MENTIONED MEDICAL PRACTICE OR ITS' REPRESENTATIVES.
- I /WE AGREE THAT PAYMENTS WILL NOT BE DELAYED OR WITHHELD, REGARDLESS OF TREATMENT OUTCOME, LAWSUITS, LIENS, OR INSURANCE COVERAGE OR THE PENDENCY OF CLAIMS THEREON. IT IS ALSO AGREED THAT ALL PROCEEDS OF INSURANCE OR MEDICAL BENEFITS PROGRAM(S) ARE ASSIGNED TO THIS MEDICAL PRACTICE WHERE APPLICABLE. I / WE UNDERSTAND THAT I AM RESPONSIBLE FOR PAYING ALL DEDUCTIBLES, CO-PAYMENTS, NON-COVERED SERVICES, AND ANY PORTION OF COVERED SERVICES NOT PAID IN FULL BY MY / OUR INSURANCE OR GOVERNMENT BENEFITS PROGRAM. SUCH PAYMENTS ARE DUE AT THE TIME OF SERVICE OR IMMEDIATELY UPON PRESENTATION OF THE BILL.

• I / WE AGREE THAT WE SHALL REMAIN FINANCIALLY RESPONSIBLE FOR THE ABOVE NAMED PATIENT UNTIL I NOTIFY YOU IN WRITING AS TO THE CONTRARY. THIS GUARANTEE IS CONTINUING EVEN IF THE ACTUAL PATIENT, IF A MINOR, REACHES THE AGE OF MATURITY.

• I / WE AUTHORIZE THE ABOVE LISTED MEDICAL PRACTICE AND ITS' AGENT(S) TO CONTACT MY INSURANCE PROVIDER AND THE EMPLOYER OF THE POLICY HOLDER TO VERIFY MY ELIGIBILITY FOR INSURANCE COVERAGE. I AUTHORIZE EXCHANGE OF MEDICAL, BILLING, AND COLLECTION INFORMATION WITH THE HEALTH CARE FINANCE ADMINISTRATION AND THEIR AGENT(S), MY / OUR INSURANCE COMPANY, AND ANY OTHER HOLDER OF INFORMATION NECESSARY TO OBTAIN PAYMENT FOR SERVICES RENDERED. IN ADDITION, I / WE AUTHORIZE YOU OR YOUR AGENT TO EXCHANGE PAST, PRESENT, AND FUTURE MEDICAL INFORMATION WITH THE PATIENT'S OTHER HEALTH CARE PROVIDERS IN ORDER TO ENHANCE AND PROMOTE THE CONTINUITY OF CARE FOR THE PATIENT.

• I / WE HEREBY NAME AS ASSIGNEE AND ALSO INSTRUCT AND DIRECT ANY AND ALL OF MY / OUR INSURANCE COMPANY AND / OR GOVERNMENT BENEFITS PAYER TO PAY BY CHECK(S) MADE OUT AND MAILED TO THE ASSIGNEE :

Thomas J. Chambers, D.P.M. 5520 E Main Street, Suite 2, Mesa, AZ 85205

• IF MY POLICY PROHIBITS DIRECT PAYMENT TO PROVIDERS, I / WE HEREBY INSTRUCT AND DIRECT THE INSURANCE COMPANY TO ASSIGN THE CHECK TO ME AND MAIL TO THE ADDRESS HIGHLIGHTED ABOVE. FURTHERMORE, I / WE GRANT LIMITED POWER OF ATTORNEY TO SIGN MY / OUR NAME, DEPOSIT, AND NEGOTIATE ANY INSURANCE PAYMENT RECEIVED, AND APPLY IT TO MY / OUR OUTSTANDING BALANCE. I / WE AGREE TO PAY ANY REMAINING BALANCE AFTER INSURANCE REIMBURSEMENT IMMEDIATELY UPON NOTIFICATION. ANY INSURANCE PAYMENTS RECEIVED BY ME FOR ANY UNPAID BALANCE WILL BE IMMEDIATELY ENDORSED TO THE MEDICAL PRACTICE LISTED ABOVE. FAILURE TO DO SO MAY RESULT IN A SERVICE CHARGE OF 1.5% MONTHLY.

• I / WE AGREE THAT A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL AND THAT THIS ASSIGNMENT SHALL REMAIN IN EFFECT UNTIL CANCELED IN WRITING BY THE ASSIGNEE.

• THIS INSTRUMENT CONTAINS THE ENTIRE AND ONLY AGREEMENT BETWEEN THE PARTIES AND THERE ARE NO OTHER PROMISES, REPRESENTATIONS, OR WARRANTIES, EITHER EXPRESSED OR IMPLIED. THE PROVISIONS OF THIS AGREEMENT SHALL NOT BE CHANGED OR MODIFIED EXCEPT FOR AN INSTRUMENT, IN WRITING, SIGNED BY THE PARTIES HERETO.

- <u>THERE WILL BE A CHARGE OF $30.00 FOR FILLING OUT DISABILITY, FMLA & SHORT-TERM DISABILITY FORMS - DUE AT THE TIME OF EACH SERVICE.</u>
- <u>I understand that there will be a $30 service charge for all returned checks</u>
- <u>Appointments Not Canceled within 24 hours of the appointment time will be subject to a $30 fee that is not payable by my insurance company.</u>

THIS IS A DIRECT ASSIGNMENT OF MY / OUR RIGHTS AND BENEFITS UNDER THIS POLICY.

I / WE HAVE READ COMPLETELY AND UNDERSTAND THE STIPULATIONS AND AGREEMENTS LISTED IN THE DOCUMENT ABOVE AND AGREE TO ABIDE BY ALL.

Please Print Name____

Signature____ Date________________

Relationship to Patient ____