YAVAPAI
FOOT and
ANKLE
CENTER

J. TODD COX, DPM
RICHARD AMUNDSEN, DPM
919 12TH Place, Suite 10
Prescott, AZ 86305-1433
928.445.4898
928.445.3802 fax

If you **have not** filled out paperwork ahead of time, please be here **15-20** minutes prior to your scheduled appointment time.

If you **have** filled out paperwork, please be here **5-10** prior to appointment.

Please bring with you your insurance card or cards, photo ID and a list of any medications you are taking. Not providing us a current medication list could impact the doctor's ability to prescribe new medications.

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Name:_____ DOB:_____ SSN:_____
Sex: __M __F Marital status: __Married __Single __Divorced __Widowed
Race: __White __Hispanic or Latino __American Indian __African American __Other
Ethnicity: __Hispanic or Latino __Not Hispanic or Latino
Preferred Language:_____
Employment Status: __ Employed __Unemployed __ Retired __ Student __Child

Address:_____ City:_____
State:_____ Zip:_____ Home #_____ Cell#_____
Email:_____

Emergency Contact: _____ Phone#: _____
Relationship: _____

Following individuals have permission to receive information about the care of above named patient:

Name: _____ Relationship: _____
Phone #: _____

Name: _____ Relationship: _____
Phone #: _____

Primary Care Physician:_____ City Located: _____
Do you have a cardiologist? __Yes __No If yes, who do you see? _____

Preferred pharmacy: _____ City & Street_____
Are you allergic to latex? __Yes __No
Do you have allergies to medications? __Yes __No
If Yes, please list: _____
Please list current medications: (if needed, attach additional page)

Medication	Dose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Insurance Information

Primary Insurance: _____
Subscriber/Member #: _____ Group #: _____
Insured's Guarantor: _____ DOB:_____
SSN: _____ Relation to patient: _____

Additional Insurance: _____
Subscriber/Member #: _____ Group #: _____
Insured's Guarantor: _____ DOB:_____
SSN: _____ Relation to patient: _____

Foot Problems:

_____

Where:_____ How long? _____ days / weeks / months / years
Pain Scale (1-10):_____ Describe pain:_____
Cause of foot problem: injury / deformity / unknown / other: _____
If an injury, was it work related? __ Yes __ No Auto accident? __ Yes __ No
If Yes, what is date of injury? _____
Aggravated by: walking / standing / shoes / physical activity

Have you ever had (circle all that apply):

hammertoes	heel spurs	calluses
ingrown toenails	corns	flat feet
toenail fungus	warts	bunions
athlete's foot	high arches	pinched nerves

Treatment provided in the past: X-rays / taping padding / medication / injections / orthotics / wound care / foot surgery.

Type of foot surgery: _____

Height: _____ Weight: _____ Shoe size: _____

Do you currently use tobacco? __Yes __No How often? _____
Have you previously used tobacco? __Yes __No Type: __Smoke ___Smokeless

Do you consume alcohol? __Yes __No
Frequency: __Daily __2-4 per week __2-4 per month __2-4 per year
Type: __Beer __Wine __Hard Liquor

Medical History (Check all that apply)

__Anemia
__Anxiety
__Arthritis
__Asthma
__BPH
__Back Problem
__CAD
__CHF
__COPD
__Cancer, type:_____
__Dementia
__Depression
__Dermatitis
__Diabetes
__Epilepsy
__GERD
__Glaucoma
__Gout
__High Cholesterol
__Hepatitis
__Hypertension
__MI (Heart Attack)
__Migraine
__Pneumonia
__Renal Stroke
__Stroke
__TB
__Thyroid Disease
__Ulcers
__Joint Replacement
__Other not listed: _____

Have you ever had a Pneumonia Immunization Injection: __Yes __No

Family History:

	Diabetes	Heart Disease	Cancer	High BP	Other
Mother					
Father					
Brother					
Sister					

How did you hear about us?
__Referral __Newspaper __Facebook __Online Search
__Mailer __Word of Mouth __Other: _____

By signing below, I attest that the information provided above is true and accurate

_____ _____/_____/_____
Signature Date

_____ _____
Print Name Relation to Patient

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Cancellation Policy/No Show Policy For Doctor Appointments and Surgery

1 . Cancellation / No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3. Cancellation / No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 10 days in advance you will be charged a seventy five dollar ($75) fee; this will not be covered by your insurance company.

4. Account balances

We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____ _____/_____/_____
Signature Date

_____ _____
Print Name Relation to Patient

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HIPAA Information and Consent Form

The Health Insurance Probability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following polices:

Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other health care providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, text, US mail, or by any means convenient for the practice and/or requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rule of HIPAA.

You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

We agree to provide patients with access to their records in accordance with state and federal laws.

We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____ _____/_____/_____

Signature Date

_____ _____

Print Name Relation to Patient

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PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

   - I understand that I am financially responsible for my health insurance deductible, co-insurance or non-covered service.
   - Co-payments are due at time of service.
   - If my plan requires a referral I must obtain it prior to my visit.
   - In the event that my health plan determines a service to be "not payable," I will be responsible for the complete charge and agree to pay the costs of all services

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
   I hereby authorize and direct payment of my medical benefits to Yavapai Foot and Ankle Center on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS
   I hereby authorize Yavapai Foot and Ankle Center to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT
   I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Yavapai Foot and Ankle Center. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____/_____/_____
Signature Date

_____ _____
Print Name Relation to Patient