

AHWATUKEE/MARICOPA FOOT & ANKLE CENTER

History & Physical

Name: _____ Date of Birth: _____ Height: _____ Weight: _____ Shoe Size: _____

Primary Care Doctor: _____ Dr's Phone Number: _____

Endocrinologist: _____ Dr's Phone Number: _____

Pharmacy: _____ Cross-streets: _____ Pharm. Phone #: _____

Patient Job title: _____ How much are you on your feet at work: ☐ 10-25% ☐ 50-75% ☐ 100%

Describe your foot/ankle problem (date of injury if relevant): _____

***Is this a work-related injury (workman's comp)?** ☐ Yes ☐ No

***If applicable, are you pregnant?** ☐ Yes ☐ No

***Past and current medical conditions:**

☐ Diabetes ☐ Type I ☐ Type II Insulin Dependent? ____ A1c: ____	☐ GI Disorder ☐ Gout	☐ Hyperthyroidism ☐ Hypothyroidism	☐ Reflux ☐ Rheumatoid Arthritis
☐ AIDS/HIV	☐ Dementia	☐ Heart Attack	☐ Kidney Failure
☐ Arthritis	☐ Dialysis	☐ Heart Disease	☐ Liver Problems
☐ Asthma	☐ Depression	☐ Heart Failure	☐ Osteoarthritis
☐ Anxiety	☐ Emphysema	☐ Hepatitis ☐ A ☐ B ☐ C	☐ Parkinson's Disease
☐ Blood Clots	☐ Epilepsy	☐ High Blood Pressure	☐ Pneumonia
☐ COPD	☐ Fibromyalgia	☐ High Cholesterol	☐ Psoriasis
☐ Cancer (type) _____	☐ Kidney Disease	Other: _____	

I have no known medical conditions: Initials _____

***History of Anesthetic Problems:** ☐ Yes ☐ No

***Allergies:**

☐ Athletic tape	☐ Adhesive	☐ Latex	☐ Eggs	☐ Anesthetics	☐ Iodine
*Allergy to Medications: _____					

I have no known allergies: Initials _____

***Are you currently taking blood thinners** (ex. Coumadin, Plavix)? : ☐ Yes ☐ No **If yes, which?** _____

***Use of recreational drugs:** ☐ Yes ☐ No **If yes, type and for how long?** _____

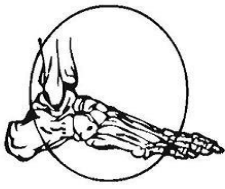
***Tobacco Use:** ☐ Never ☐ Ex-Smoker. Quit _____ ago. ☐ Current Smoker. ____ pack(s) daily for _____ years.

***Past Surgeries/Hospitalizations (last 3 years):**

I have not had any surgeries in the past three years: Initials _____

***Family History:**

☐ Diabetes	☐ Heart attack	☐ Cancer (type) _____	☐ Unknown	☐ None
☐ Gout	☐ Heart Disease	☐ High Blood Pressure	Other: _____	



AHWATUKEE/MARICOPA FOOT & ANKLE CENTER

Current Medications

Name: _____

DOB: _____

Please list all current medications (prescription and over-the-counter), including their dosages and frequencies.

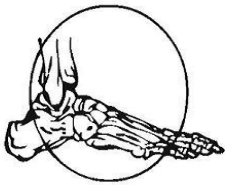
<u>Medication</u>	<u>Dose</u>	<u>How many times a day</u>

I am currently not taking any medications: Initials _____

By signing this form, I confirm that the information above is current and correct. I also acknowledge that it is my responsibility to notify Ahwatukee/Maricopa Foot and Ankle Center of any changes or if I stop taking any medications.

SIGNATURE OF THE PATIENT OR PARENT/LEGAL GUARDIAN

DATE



AHWATUKEE/MARICOPA FOOT & ANKLE CENTER

Financial Policy

Due to new insurance requirements, the following policy has been established. Please read it carefully, as there are no exceptions.

We strive to ensure that all services align with your insurance requirements. However, benefits can vary widely, even within the same insurance company, depending on the specific plan chosen by the employer or applicant. This means that coverage isn't always the same for every employee, even with the same insurer. Your insurance company expects you to know and understand your own policy. Since we cannot be familiar with every individual policy, we cannot guarantee that all services will be covered. **It is your responsibility to verify benefits and coverage details before receiving any services.**

TIMELY FILING:

Insurance companies require claims to be submitted within specific time frames, and we do our best to follow these guidelines. However, **if your insurance changes and you don't inform us**, we may miss the deadline to bill the correct company, **you will be responsible for the payment.** If we aren't notified of changes, our only indication may be a denial from your previous insurer, which often arrives after the deadline.

You will be responsible for payment of all services if any of the following apply and not limited to:

- **If you have a Workers' compensation claim but fail to notify us at your FIRST VISIT.**
- **If you do not have insurance.**
- **If you do not have a referral when required by your insurance company.**
- **If you are with an insurance company with which we are not contracted with.**
- **If your insurance company denies your claim for any reason, you are responsible for all appeals.**
- **If you have given us incorrect insurance information, a \$100 fee will be charged.**

REBILLING FEE:

Due to the nature and volume of work required to resubmit claims to your correct insurance, for each date of service, you will be charged a \$100 fee.

MINORS:

A parent or legal guardian **must** accompany a minor patient on their first visit to our office. For subsequent visits, the minor must be accompanied by an adult over the age of 21 who can make financial and medical decisions. **The parent or guardian accompanying the child is responsible for all charges on the date of service.** We cannot be aware of arrangements made between divorced parents and the courts regarding the child's care and payment of bills.

MEDICARE PATIENTS:

We are a participating Medicare provider, which means we must bill Medicare directly. After you meet your annual deductible, Medicare will cover 80% of the allowable amount, while **the remaining 20% and the deductible are your responsibility.** If you have a secondary insurance plan, we will bill it for you, provided we have your current and complete information. If you have a Medicare replacement plan, your Medicare Part B is invalid, and we may not be in-network with all replacement plans. **It is your responsibility to verify if we are contracted with your plan/insurance.**

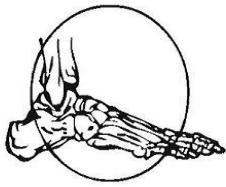
DELINQUENT ACCOUNT:

To the best of our ability, all co-pays, coinsurance, and deductibles are collected at the time of service based on the information provided by your insurance. Please note that these amounts may change once the claim is processed. **If your account becomes delinquent, a 30% interest fee will be applied to the overall balance.**

By signing this form, I confirm that I understand the information above, authorize the release of necessary medical information for my claims, and approve payment of benefits to Ahwatukee/Maricopa Foot and Ankle Center or its suppliers for services provided.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE



AHWATUKEE/MARICOPA FOOT & ANKLE CENTER

Office Policies

APPOINTMENTS:

Our doctors are surgeons and may have emergency walk-ins or surgeries that can cause delays. We appreciate your patience and will see you as soon as possible, giving full attention to your needs when the doctor is available.

Please provide at least 24 hours' notice for canceled appointments. A \$50 fee will be charged for missed appointments or cancellations made within 24 hours.

BILLING:

Allow 24-48 hours for a response to billing inquiries. Billing issues often require investigation, so please leave a clear message with your name and/or patient's name, date of birth, phone number, and concerns. Credits will not be refunded until all charges are processed and your account has been audited. Significant outstanding balances must be settled before future visits. We do not accept checks.

PRESCRIPTIONS:

Our policy requires that all prescription refill requests be made directly with us, not through your pharmacy. To ensure timely refills, discuss your medications with your doctor during your appointment or call our office with the medication name, allowing 48-72 hours for processing. **Notify us 3-4 days before your medication runs out.** If you need a written prescription, please allow an additional 24-48 hours for pickup, and we will notify you when it's ready. **A doctor's visit is required before refills can be issued for pain medications and maintenance prescriptions over three months old.**

ORTHOTICS, DURABLE MEDICAL EQUIPMENT AND SHOES:

All orthotics, braces, splints, boots, post-op shoes and any other medical equipment/supply are non-returnable and non-refundable. Charges apply once these items leave our office. Please verify coverage with your insurance, as you will be responsible for any uncovered charges. Once orthotics have been cast, you are liable for the full balance. A fee will apply for any orthotics adjusted or repaired after 90 days. Unworn shoes may be returned within 30 days. For worn shoes returned after this period, the manufacturer may accept the return on a case-by-case basis; a \$15 shipping fee will apply.

SURGERY:

Scheduling surgery is time-intensive and **requires a \$100 deposit, which is non-refundable if the surgery is canceled.** During the post-operative period, you may still be charged a co-pay or co-insurance for services based on your insurance. **Additionally, co-pays and/or co-insurance will apply for any services not directly related to your surgery.**

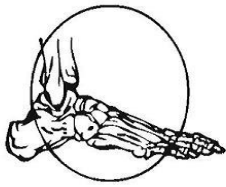
FORMS AND MEDICAL RECORDS:

There is no charge for medical records requested by a physician or patient unless the records are archived. Archived records require a \$50 fee. Forms required for Workers' Compensation, Disability, and Family Leave have a minimum fee of \$25. Compiling medical records is time-intensive and may take several weeks to process. All forms are completed after hours in the order they are received.

By signing this form, I confirm that I have read and understand the office policies.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE



AHWATUKEE/MARICOPA FOOT & ANKLE CENTER

Notice of Privacy Practices

Ahwatukee/Maricopa Foot and Ankle Center is committed to protecting the privacy of your **Protected Health Information (PHI)**. This notice explains how we may use and share your information and your rights regarding your PHI.

How We Collect Your Information: Information may be collected directly from you or healthcare providers involved in your care. If your pharmacy is linked to the Surescripts network, we may also receive prescription information.

How We Use Your Information: Your PHI may be used or shared as permitted or required by law for:

- **Treatment:** Providing and coordinating your podiatric care, including referrals, prescriptions, imaging, procedures, wound care, and communication with other healthcare providers.
- **Payment:** Verifying insurance, obtaining prior authorization, submitting claims, and collecting payment.
- **Healthcare Operations:** Maintaining medical records, improving care, training staff, and operating our practice.
- **Other Permitted Uses:** Public health, healthcare oversight, legal requirements, law enforcement, workers' compensation, and coroners or medical examiners when permitted or required by law.

Access to your PHI may include individuals you designate in writing, those directly involved in your care, those responsible for maintaining your medical record, and entities involved in processing healthcare claims and payments.

AI-Assisted Technology and Voice Recording: We may use AI-assisted technology, including voice recording, to help document your visit and organize information for your medical record. These tools assist our healthcare providers but do not replace their clinical judgment. AI-assisted documentation is reviewed by appropriate practice personnel and may become part of your medical record.

Information processed through these technologies is protected in accordance with applicable privacy and security requirements, including HIPAA. **We do not sell your PHI or your personal or health information.**

You have the right to:

- Access and receive a copy of your medical information.
- Request corrections to your information.
- Request restrictions or confidential communications as permitted by law.
- Receive a copy of this notice.
- File a complaint if you believe your privacy rights have been violated.

How We Protect Your Information: We use physical, electronic, and administrative safeguards to protect your PHI and limit access to those who need it for treatment, payment, healthcare operations, or other permitted purposes.

Our Legal Duties: We are required by law to protect your PHI, provide this notice, and follow the privacy practices described here. We may update this notice as required by law.

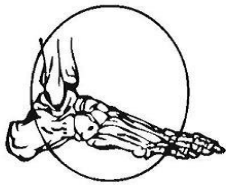
Questions or Complaints: Please contact our office manager at **480-893-1090**. You may also file a complaint with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Acknowledgment:

I acknowledge that I received the Notice of Privacy Practices.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE



AHWATUKEE/MARICOPA FOOT & ANKLE CENTER

Demographic Information

PATIENT INFORMATION:

Patient Name: _____
Last name

First name _____ Middle initial _____

Date of Birth: _____ Gender: _____

SS # _____

Address: _____

City: _____

State: _____ Zip: _____

Permanent Address (if different from above)

E-Mail: _____

Marital status: _____ Race: _____

INSURANCE INFORMATION:

Relationship to Insured: (Circle) SELF SPOUSE CHILD OTHER

Insured/Responsible Party Name:

Insured/Responsible Party Address: _____

Birth date: _____ SS#: _____

Secondary Insurance: _____

If you provide secondary insurance later, there will be a \$100 fee for each date of service that needs adjustment.

*****IF YOU HAVE: TRICARE, TRIWEST, WPS OR VAP*****

We need: Social Security number, Sponsors Name, DBN/DOD number and address to bill claims.

PHONE NUMBERS:

Home Phone (____) _____

Work Phone (____) _____

Cell Phone (____) _____

Best time of day to reach you: _____

Emergency Contact: _____

Emergency Contact Phone: (____) _____

HIPPA Acknowledgement

I have received a copy of the Privacy rules from Ahwatukee/Maricopa Foot and Ankle Center. I authorize the following list of people who may receive my Protected Health Information (Ex. spouse, family member). I understand that I may revoke this authorization at any time by giving written notification to this office.

These people may receive my Protected Health Information:

Name: _____

Date of Birth: _____

Relationship to Patient: _____

Alternate Phone Number: _____

Name: _____

Date of Birth: _____

Relationship to Patient: _____

Alternate Phone Number: _____

☐ I do not wish to list anyone at this time: Initials _____

General messages about appointments, billing, and test results may be left on your answering machine/voicemail.

For detailed messages, I give permission to leave them on the phone number(s) listed below:

☐ Cell # _____

☐ Home # _____

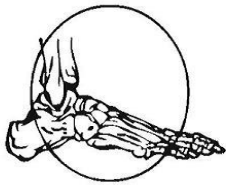
☐ Work # _____

Whom may we thank for referring you?

I hereby consent that all information provided is current and correct.

SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN

DATE



AHWATUKEE/MARICOPA FOOT & ANKLE CENTER

Policy for Appropriate Conduct

At Ahwatukee Foot and Ankle, our goal is to ensure a safe workplace for our employees and a comfortable environment for our patients and others we interact with. We treat all patients with dignity and respect and ask that our patients and their representatives do the same.

We expect patients and their representatives to follow these behaviors, including but not limited to:

- Using a normal tone of speech when speaking with staff.
- Treating all staff with dignity and respect whether in clinic or on the phone.
- Using appropriate language when speaking in the clinic or on the phone.
- Being respectful of the practice's property and supplies.

Depending on the situation, Ahwatukee/Maricopa Foot and Ankle may consider certain behaviors a violation of this policy. Violations may result in verbal counseling or discharge from the practice.

Our patients are very important to us. While we strive to accommodate schedules, appointments will depend on staffing and individual medical needs.

By signing below, I acknowledge the above information and agree to abide by these guidelines for appropriate conduct.

Please PRINT Patient Name

Date of Birth (DOB)

Patient/Guardian SIGNATURE

Date