

**AHWATUKEE/MARICOPA FOOT & ANKLE CENTER**

## History & Physical

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Shoe Size: _____

Occupation: _____

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

Primary Care Physician: _____ PCP Phone: _____

Endocrinologist: _____ Dr's Phone: _____

Pharmacy: _____ Cross Streets/Phone: _____

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

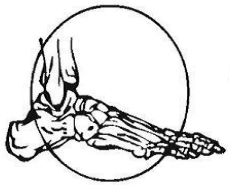
_____

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

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

*** Past and current medical conditions:**

<table>
<tr><td>☐ Type 1 Diabetes<br>☐ Type 2 Diabetes<br>Insulin-dependent? ☐ Yes ☐ No<br>Most recent A1c: _____</td><td>☐ Hyperthyroidism<br>☐ Hypothyroidism<br><br>☐ Anxiety<br>☐ Depression</td><td>☐ Arthritis<br>☐ Osteoarthritis<br>☐ Rheumatoid Arthritis<br>☐ Gout. ☐ Current ☐ Past</td></tr>
<tr><td>☐ Kidney Disease<br>☐ Kidney Failure<br>☐ Dialysis: ☐ Past ☐ Current:<br>Frequency: _____</td><td>☐ Cancer: Type:<br>_____<br>☐ On current treatment<br>☐ In remission<br>☐ Past history</td><td>☐ Liver Problems: Type:<br>_____<br>☐ Acid Reflux (GERD)<br>☐ Stomach Ulcer<br>☐ GI Disorder</td></tr>
<tr><td>☐ Blood Clots:<br>☐ Leg (DVT) ☐ Lung (PE)<br>☐ Current ☐ Past (Year: _____)<br>Blood thinner? ☐ Yes ☐ No</td><td>☐ AIDS/HIV<br>☐ Pneumonia<br>☐ Tuberculosis<br>☐ Valley Fever</td><td>☐ Dementia<br>☐ Parkinson's Disease<br>☐ Seizures/Epilepsy<br>Current seizures? ☐ Yes ☐ No</td></tr>
<tr><td rowspan="2">☐ Heart Disease<br>☐ Heart Attack<br>☐ Heart Failure<br>☐ High Blood Pressure<br>☐ High Cholesterol</td><td>☐ Asthma<br>☐ COPD/Emphysema<br>☐ Sleep Apnea</td><td>☐ Stroke<br>☐ Peripheral Neuropathy (nerve damage/numbness in feet)</td></tr>
<tr><td>☐ Fibromyalgia<br>☐ Psoriasis</td><td>☐ Leg/Foot Ulcers<br>☐ Foot/Ankle Fracture</td></tr>
<tr><td colspan="3">☐ Other:</td></tr>
<tr><td colspan="3">☐ No known medical conditions</td></tr>
</table>



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Name: _____ Date of Birth: _____

*** Current Medications:**

| Medication | Dose (milligrams) | How many times a day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**I am currently not taking any medications**: Initials _____

*** Allergies:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ Athletic tape | ☐ Adhesive | ☐ Latex | ☐ Eggs | ☐ Anesthetics | ☐ Iodine |
| ☐ **Allergy to Medications:** | | | | | |
| ☐ **No known drug allergies** | | | | | |

*** Social History:**

| |
|---|
| **Anesthesia Problems** ☐ Yes ☐ No If yes, please explain: _____ |
| **Are you currently taking blood thinners** (e.g., Coumadin, Plavix)**?** : ☐ Yes ☐ No<br>If yes, which? _____ |
| **Use of recreational drugs:** ☐ Yes ☐ No If yes, which drugs? _____ |
| **Tobacco Use:**<br>☐ Never ☐ Ex-smoker. Quit _____ ago. ☐ Current Smoker. ___ pack(s) daily for _____ years. |

*** Surgical History:** _____

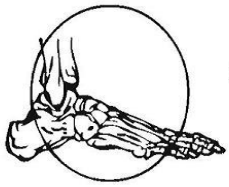
_____

_____

☐ **I have not had any surgeries**

*** Family History:**

| | | | |
|---|---|---|---|
| ☐ Diabetes | ☐ Heart attack | ☐ Cancer: Type: _____ | **Other:** |
| ☐ Gout | ☐ Heart Disease | ☐ High Blood Pressure | |
| ☐ **Unknown family history** | | ☐ **No family history of illnesses** | |



**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.

Insurance coverage varies by plan, even within the same insurance company. While we do our best to help you understand your benefits, we cannot guarantee that all services will be covered. **Please verify your benefits and coverage with your insurance company before receiving services.**

TIMELY FILING: Please let us know if your insurance changes so we can bill the correct insurance company on time. Insurance companies have strict filing deadlines, and we may not know your coverage has changed until insurance denies the claim. **If we are not notified in time to bill your new insurance before the deadline, you may be responsible for the charges.**

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.**
- **If you are with an insurance company with which we are not contracted with.**
- **If your insurance denies a 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: If a claim must be resubmitted due to incorrect or outdated information, a $100 fee will apply for each date of service.

MINORS: A parent or legal guardian must accompany minors on their first visit. For all future visits, the minor must be accompanied by a parent, legal guardian, or adult age 21 or older authorized to make medical and financial decisions. **The accompanying adult is responsible for all charges incurred.** Our office cannot enforce agreements between divorced parents regarding medical care or payment.

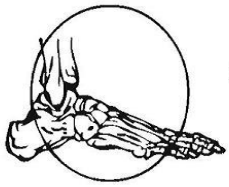
MEDICARE PATIENTS: We are a participating Medicare provider and bill Medicare directly. After your annual deductible is met, Medicare generally covers 80% of the approved amount, and you are responsible for the remaining 20% and any unmet deductible. We will bill your secondary insurance if we have your current information. If you have a Medicare Advantage (replacement) plan, your coverage and costs may differ.**Please verify that we are in-network with your plan before receiving services.**

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, I acknowledge the above, authorize necessary medical information sharing, and approve payment of benefits to Ahwatukee/Maricopa Foot & Ankle Center or its suppliers for services provided.**

_____

*** SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN** *** DATE**



**AHWATUKEE/MARICOPA FOOT & ANKLE CENTER**

## Office Policies

APPOINTMENTS:
Our doctors perform surgeries and may need to handle emergencies, which can cause delays. Thank you for your patience. We will see you as soon as possible and give your needs our full attention. **Please provide at least 24 hours' notice for cancellations. Missed appointments or cancellations made with less than 24 hours' notice will incur a $50 fee.**

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:
Please request all prescription refills directly through our office, **not your pharmacy**. Discuss refills with your doctor at your appointment or call our office with the medication name. Allow 48–72 hours for processing and notify us 3–4 days before your medication runs out. **A doctor's visit is required before refills can be issued for pain medications and maintenance prescriptions over three months old.**

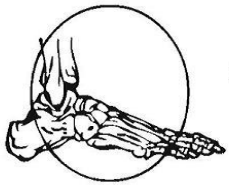
ORTHOTICS, DURABLE MEDICAL EQUIPMENT AND SHOES:
**All orthotics, braces, splints, boots, post-op shoes and any other medical equipment/supply are non-returnable and non-refundable.** Charges apply once these items leave our office. Please verify coverage with your insurance, as you will be responsible 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.** Surgery-related office visits are covered during the post-operative period. Additional services and visits unrelated to your surgery may incur charges based on your insurance.

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 PARENT/LEGAL GUARDIAN** *** DATE**



**AHWATUKEE/MARICOPA FOOT & ANKLE CENTER**

## Notice of Privacy Practices

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

**How We Collect Your Information:** We may receive your information from you, your healthcare providers, or your pharmacy through the Surescripts network, when available.

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

- **Treatment:** Providing and coordinating your care, including referrals, prescriptions, imaging, procedures, and communication with other healthcare providers.
- **Payment:** Verifying insurance, obtaining authorization, submitting claims, and collecting fees.
- **Healthcare Operations:** Maintaining medical records, improving care, training staff, and managing our practice.
- **Other Permitted Uses:** Public health, healthcare oversight, law enforcement, workers' compensation, and other legally permitted or required disclosures.

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 Documentation:** 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.

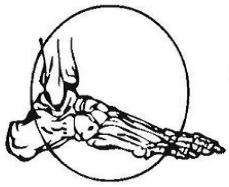
**How We Protect Your Information:** We use physical, electronic, and administrative safeguards to protect your PHI and limit access to those who need it for treatment, payment, healthcare operations, or other permitted purposes.

**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 or file a complaint with the U.S. Department of Health and Human Services. You will not be penalized.

**Acknowledgment:** I have reviewed the Privacy Practices from Ahwatukee/Maricopa Foot and Ankle Center and understand my rights regarding the disclosure of my Protected Health Information.

*** PATIENT INITIALS: _____ * DATE: _____**



**AHWATUKEE/MARICOPA FOOT & ANKLE CENTER**

## Authorization to Disclose Health Information:

I authorize the individuals listed below to receive my Protected Health Information (PHI).

**Authorized Individual 1**

Name: _____ Date of Birth: _____

Relationship to Patient: _____

Alternate Phone Number: _____

**Authorized Individual 2**

Name: _____ Date of Birth: _____

Relationship to Patient: _____

Alternate Phone Number: _____

☐ **I do not wish to put anyone at this time.**

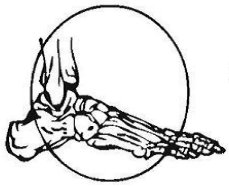
**Permission to Leave Voicemail Messages:** General messages about appointments, billing, and test results may be left on your voicemail. Detailed messages may be left at the phone number listed below:

**Phone number:** _____

**I have received a copy of the Privacy Rules from this provider and authorized the above list of people who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.**

_____

*** SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN** *** DATE**



**AHWATUKEE/MARICOPA FOOT & ANKLE CENTER**

## Demographic Information

Patient Name (Last/First/MI): _____ / _____ / _____

Date of Birth: _____ Gender: _____ SS #: _____

Marital Status: _____ Race: _____

Address: _____ City: _____ State: _____ ZIP: _____

Permanent Address: _____

_____

Email Address: _____

**Home Phone:** _____ **Cell Phone:** _____ **Work Phone:** _____

Emergency Contact: _____ Phone: _____

**- How would you prefer to receive appointment reminders?** ☐ Phone Call ☐ Text ☐ None

**** If insurance information is incorrect or not provided in a timely manner, there will be a $100 fee for each date of service that needs adjustment. ****

**PRIMARY INSURANCE:**

Relationship to Insured: (Circle) SELF SPOUSE CHILD OTHER

Policyholder's Name: _____ DOB: _____ **SS #:** _____

Address: _____ City: _____ State: _____ ZIP: _____

Insurance Name: _____ ID #: _____ Group #: _____

Insurance Address: _____ City: _____ State: _____ ZIP: _____

**SECONDARY INSURANCE:**

Relationship to Insured: (Circle) SELF SPOUSE CHILD OTHER

Policyholder's Name: _____ DOB: _____ **SS #:** _____

Address: _____ City: _____ State: _____ ZIP: _____

Insurance Name: _____ ID #: _____ Group #: _____

Insurance Address: _____ City: _____ State: _____ ZIP: _____

*****TRICARE, TRIWEST, WPS OR VAP*****

**SS #:** _____ Sponsors Name**:** _____ DBN/DOD #**:** _____

Address: _____ City: _____ State: _____ ZIP: _____

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

_____

*** SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN** *** DATE**