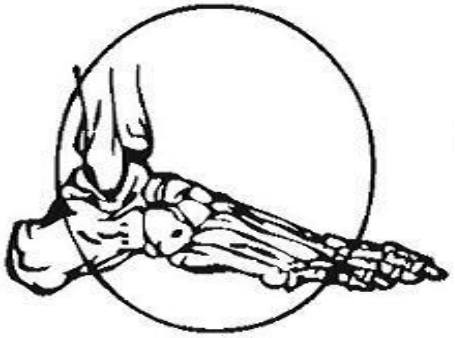


Dr. Kelvin Crezee, DPM, FACFAS
Dr. C. Jon Beecroft, DPM
Dr. Alex M. Stewart, DPM, FACFAS

Ahwatukee Foot & Ankle Center
15810 S. 45th St. Suite 190
Phoenix, AZ 85048
Phone: (480) 893-1090
www.ahwfac.com

Maricopa Foot & Ankle Center
21300 N. John Wayne Pkwy, Suite 126
Maricopa, AZ 85139
Phone: (520) 494-1090
www.mfaac.com

History & Physical

Name: _____ Date of Birth: _____ Height: _____ Weight: _____ Shoe Size: _____
Primary Care Doctor: _____ Phone Number: _____
Endocrinologist: _____ Phone Number: _____
Pharmacy: _____ Cross-streets: _____ Phone Number: _____
Please describe your problem (include date of injury if applicable): _____
Is this a work-related injury? ___Yes ___No If applicable, are you pregnant? ___Yes ___No

Past Medical Conditions: Please **CIRCLE** any illness that apply:

Diabetes **Type I** OR **Type II** Insulin Dependent? __ A1c: ___		Epilepsy	Heart Failure	Kidney Failure	Seizures
		Fibromyalgia	Hepatitis A, B or C	Osteoarthritis	Sleep Apnea
AIDS/HIV	Cancer _____	GI Disorder	High Blood Pressure	Pneumonia	Stomach Ulcer
Arthritis	COPD	Gout	High Cholesterol	Psoriasis	Stroke
Asthma	Dialysis	Heart Attack	Hyperthyroidism	Reflux	Tuberculosis
Blood Clots	Emphysema	Heart Disease	Hypothyroidism	Rheumatoid Arthritis	Valley Fever
History of Anesthetic Problems: Yes or No			Kidney Disease	**OTHER:**	

Allergies: Please **CHECK** all allergies:

___ Athletic Tape ___ Adhesive ___Latex ___Eggs ___Anesthetics ___ Medications: _____

Current Medications: Please list dosage and frequency for all prescription and over-the-counter medications.

_____
_____
_____

Are you currently taking: **Coumadin** or **Plavix** (Blood thinners)? _____
Do you take any **drugs** for **non-medical use**? Yes or No If so, what? _____

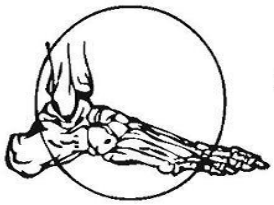
Smoking status: ___ Never Smoked. ___ Ex-Smoker. ___ Current Smoker. How much? _____ How long? _____

Past Surgeries/Hospitalizations: (Please List)

_____
_____

Family History: Please list any medical condition that applies such as heart disease, diabetes, cancer, etc.

Family Member	Living	Deceased	Age	Medical Condition
Mother				
Father				
Sister(s)				
Brother(s)				



AHWATUKEE/MARICOPA FOOT & ANKLE CENTER

Financial Policy

Due to increased insurance company demands, the following policy has been established for this office. There are **no exceptions** to this policy. Please read this policy carefully.

We make every attempt to ensure that all services are compatible with your special insurance requirements. However, all policies have different benefits, depending on the requests and desires of the employer or applicant. Benefits are not always available to all employees, even if they have the same insurance company. Your insurance company informs all participants that it is ultimately your responsibility to know and understand your policy with the insurance company. **We do not have the capability to know each individual policy, as it varies per patient. We cannot guarantee all services will be covered.** It is your responsibility to verify all benefits and coverage information prior to having any services rendered.

Insurance companies require that we submit all claims within a specified time limit. We do our best to follow all guidelines set forth by your insurance company. However, if your insurance changes and you fail to inform us, we may be unable to bill the appropriate company within these time limits. If you do not provide new information, a denial from the previous carrier is our only way of knowing your insurance has changed. Denials are generally not returned to us until after the filing deadline. Therefore, if you do not notify us of any changes, you will be responsible for payment of services for your benefits. Please notify us of any changes as soon as possible.

You will be responsible for payment of all services if any of the following circumstances apply:

- **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 we are not contracted with.**
- **If your insurance company denies your claim for any reason that is not resolvable.**

MEDICARE PATIENTS: We are a participating Medicare provider, which means we must bill Medicare directly. Medicare will pay us 80% of the allowable amount *after you have met your annual deductible.* The remaining 20% and deductible are your responsibilities. If you have a secondary insurance plan, we will bill it for you, provided we have your current and complete information. Be aware that if you have enrolled in a Medicare replacement plan, your Medicare part B is now invalid. We may not be in network with all Medicare replacement plans.

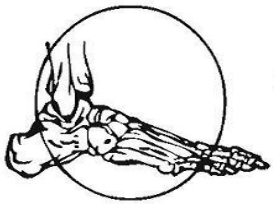
A fee will be accessed if the wrong insurance information is given. If you forget to give us new insurance information, there will be a re-billing fee of $25.00-$100.00.

A parent/legal guardian **must** accompany a minor patient on his/her first visit to our office. On subsequent visits, minor patient needs to be accompanied by an adult over the age of 21 years old that can make financial and medical decisions rendered at each visit and are responsible for charges on the date of service. We are not and cannot be aware of the arrangements made between divorced parents and the courts for the child's care and payment of bills. The parent that accompanies the child is responsible for all payments on the date of service

- **ALL CO-PAYS, COINSURANCE AND DEDUCTIBLES ARE COLLECTED AT THE TIME OF SERVICE.**

By signing this form, I understand all the information listed above, authorize the release of any medical information necessary to process your claims and authorize payment of medical benefits to Ahwatukee/Maricopa Foot and Ankle Center or supplier for services rendered.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE



AHWATUKEE/MARICOPA FOOT & ANKLE CENTER

Office Policies

APPOINTMENTS:
Dr. Crezee, Dr. Beecroft, and Dr. Stewart are surgeons. They regularly have emergency walk-ins and emergency surgery that may lead to delays. You will be seen as soon as possible, so please be patient. Full attention will be given to you and your needs when the doctor sees you. Thank you for your patience.
We require 24 hours notice for cancelled appointments. Patients who miss appointments will be assessed a $50.00 fee.

BILLING:
Please allow 24-48 hours for billing questions and a return call. Billing frequently requires investigation and research to resolve a problem. When leaving a message, please clearly state your name and/or patient's name, phone number and concerns. Please provide us with your email address.
Significant outstanding balances will be collected and/or any arrangements made for payment before being seen for future visits. We do not accept checks, we apologize for the inconvenience.

PRESCRIPTIONS:
It is best to discuss your medications with your doctor during an office visit. Please do not let your medication run out. Please notify your pharmacy 3-4 days before you run out of your prescription. If you need a written prescription, please allow 24-48 hours for pick up. We will notify you when it is ready to be picked up. The doctor will need to see you before prescribing any pain medication and for maintenance medications if over 3 months.

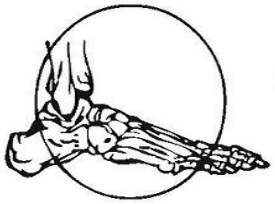
ORTHOTICS, DURABLE MEDICAL EQUIPMENT AND SHOES:
Orthotics, braces, splints, boots and post op shoes are **non-returnable and non-refundable**. Please check with your insurance provider for coverage information. If your insurance does not cover them, you are responsible for all charges. Once orthotics are cast, you are responsible for the full balance. Charges for braces, splints, boots and post-op shoes that are taken out of our office are your responsibility. There will be a fee for orthotics that are adjusted/repaired after 90 days. When shoes are purchased, please try them on in the office. Unworn shoes that are taken out of the office may be returned, however, there will be a $15.00 restocking/shipping charged assessed.

SURGERY:
Booking surgery is time intensive. There will be a **$100.00 surgery deposit** when you schedule a surgery, this will not be returned if you cancel surgery.
During the post-operative period, patients may still be charged a co-pay or co-insurance for services, depending on your insurance. If services are performed that are not directly related to your surgery, your co-pay and/or co-insurance will be due.

FORMS AND MEDICAL RECORDS:
When a physician or a patient request medical records there is no charge, unless the records are archived. Medical records in storage will require a $50.00 fee. Forms required by Workers Compensation, Disability and Family Leave will require a minimum fee of $25.00. Compiling medical records is time intensive and may take several weeks to process. All forms are filled out after hours in the order they are received. A copy of your digital x-rays is $5.00 per CD.

I have read and understand the office policies:

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE



AHWATUKEE/MARICOPA FOOT & ANKLE CENTER

Notice of Privacy for Protected Health Information (Phi)

The office of Ahwatukee/Maricopa foot and ankle center is dedicated to protecting your "nonpublic personal health information." This notice is to tell you how and why we collect that information, and who has access to that information.

HOW WE COLLECT YOUR INFORMATION:
Your personal demographic information such as name, address, birth date, social security number and medical insurance information is obtained from you. Therefore, we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card. This ensures that the information we collect is correct.

If you came to our practice through a hospital encounter, we may obtain that information from the hospital. However, on your first visit to this office, we will ask you to fill out our information sheet to ensure that the information we received from the hospital is correct. We may also ask a doctor or other health care provider who referred you to this practice to give us health information that will enable us to better treat your medical condition. This benefits you in that we will have test results that have already been obtained by the referring entity. We may also get information about your prescriptions if your pharmacy is linked to the Surescripts network.

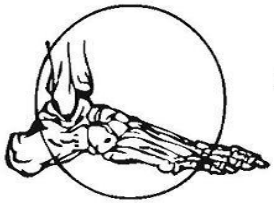
WHY WE COLLECT THIS INFORMATION:
We collect this information so that we can treat your medical condition and obtain payment from your health insurance.

MAINTAINING ACCURATE AND TIMELY INFORMATION:
To ensure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

WHO HAS ACCESS TO THIS INFORMATION:
Any persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for our services have access to your Protected Health Information. Entities such as Government Oversight Agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners **may** obtain copies of your Protected Health Information. Law mandates these entities and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION:
We release your information only to these people who need your information. We maintain physical, electronic and procedural safeguards so that only persons involved in your health care or entities that need this information for claims processing have access to your Protected Healthcare Information.

COMPLAINTS/COMMENTS:
If you feel your privacy rights have been violated you may file a written complaint at our office or you may contact the practice at 480-893-1090.



AHWATUKEE/MARICOPA FOOT & ANKLE CENTER

Demographic Information

PATIENT INFORMATION:

Patient Name: _____
Last name

_____
First name Middle initial

SS # _____

Address: _____

City: _____

State: _____ Zip: _____

Permanent Address (if different from above)

_____

_____

E-Mail: _____

Gender: _____ Age: _____ Birth date: _____

Marital status: _____ Race: _____

Patient Employer: _____

Employer address: _____

_____

INSURANCE INFORMATION:

Relationship to Insured: (Circle) SELF SPOUSE CHILD OTHER

Insured/Responsible Party Name: _____

Insured/Responsible Party Address: _____

_____

Birth date: _____ SS#: _____

Employer: _____

*****IF YOU HAVE: TRICARE, TRIWEST, WPS OR VAP*****
We need: Social Security number, Sponsors Name, 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: _____

Name: _____
Date of Birth: _____
Relationship to Patient: _____
Alternate Phone Number: _____

Messages may be left on your answering machine/voicemail regarding appointments, billing and test results.

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