

REGISTRATION

Date _____ Home Phone _____ Cell Phone _____ Email _____
 Patient Last Name _____ First Name _____ Initial _____
 Street Address _____
 City _____ State _____ Zip _____
 Sex M F Age _____ Birth date _____ Single Married Widowed Separated divorced
 Social Security # _____ Driver's License # _____
 Insured Name _____ Insured's Birth date _____ How and where did you learn about this clinic? _____
 Last Name First Name In
 Relationship to Insured Self Spouse Child Other
 Condition/Illness Related To Illness Employment Auto Other

EMPLOYER	Company Name _____ Occupation _____ Address _____ Phone _____ <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time City _____ State _____ Zip _____ Years Employed _____
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SPOUSE (PARENT)	Name _____ Birth date _____ SSN: _____ Last Name First Name Initial Employer Name _____ Years Employed _____ Address _____ Phone _____ Occupation _____ City _____ State _____ Zip _____ <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
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PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name _____ Policy/Group #: _____ Effective Date: _____ Name of Insured: _____ ID #: _____
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SPOUSE COINSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plane Name _____ Policy/Group #: _____ Effective Date: _____ Name of Insured: _____ ID #: _____
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MEDICAL AND LEGAL INFORMATION	<p>Are you present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? <input type="checkbox"/> Yes <input type="checkbox"/> No Your Initials: _____</p> <p>If you answered yes, please fill out accident specific form, available at the front desk.</p> Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No Family Physician _____ Person to contact in emergency (Name and Phone #) _____ Attorney _____ Telephone: _____ Address: _____
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PATIENT AGREEMENT	<p>LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS</p> <p>In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to <u>Tri-County Foot & Ankle Centers; LTD</u>. All medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/ or employee health benefits claim submissions.</p> <p>I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medial benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against such insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.</p> <p>Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti assignment is waived.</p> <p>This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.</p> <p>_____ Signature of Insured/Guardian _____ Date</p>
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MEDICAL INFORMATION

This Information Is Important For Our Records and Your Health

Describe your foot problem:

How long has it been bothering you? Days Weeks Months Years

Any past problems of your feet and ankles?

Any past surgical procedures on your feet or ankles?

Shoe size Current Weight Height

Are you allergic or sensitive to?

Antibiotics (Penicillin, Sulfa drugs, etc.?)

Any Medicines Allergies?

Tape? Betadine (Iodine)?

Other?

Have you had problems taking aspirin or ibuprofen (Advil, Motrin)? yes No

Any problems with local anesthetics (Novocaine, Lidocaine)? Yes No

GENERAL HEALTH INFORMATION

Do you have diabetes? Yes No If yes, do you take insulin? Yes No Number of years?

Have you had any serious illnesses? Yes No If yes, for what conditions?

Have you had any major surgeries? Yes No If yes, for what conditions?

Are you under a physician's care? Yes No If yes, for what conditions?

Physicians name Date you last saw this Doctor:

May we contact your physician about your health? Yes No

What medications do you take regularly?

Check any of the following you have, or have had problems with:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Heart | <input type="checkbox"/> Asthma or Breathing Difficulty | <input type="checkbox"/> Skin | <input type="checkbox"/> Unexplained fever |
| <input type="checkbox"/> Circulation | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Gout | <input type="checkbox"/> Unexplained Weight Loss |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hormones | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Frequent Infections |
| <input type="checkbox"/> Kidneys or Bladder | <input type="checkbox"/> Anemia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Healing |
| <input type="checkbox"/> Lungs | <input type="checkbox"/> Bladder | <input type="checkbox"/> Liver | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Cancers | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Eye, Ear, Nose, or Throat | <input type="checkbox"/> Intestines |

Do you have any artificial joints?

- Hip Yes No Right / Left
Knee Yes No Right / Left
Other _____

Do you have Heart Valve Implant?

- Yes No

Do you have a Mitral Valve Prolapse?

- Yes No

Family History:

- Mother: Living Deceased Cause of Death _____
Father: Living Deceased Cause of Death _____
Brother: Living Deceased Cause of Death _____
Sister: Living Deceased Cause of Death _____

Is there a family (blood relative) history of:

- | | |
|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Bunions |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hammertoes |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Flatfeet |
| <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Circulation problems in leg or feet? |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes |

Do you smoke?

- Yes # packs per day? _____ No

Previously Smoked?

- Yes # of years? _____ No

Do you drink alcohol or beer?

- Yes No

- Light usage 1-2 per week Moderate 1-2 per day Heavy more than 2 daily

Recreational drug use?

- Yes No

- Employment: Sit at job Stand at job Stand & walk at job Retired

Signature: _____

Date: _____

Patient Financial Policy

We are dedicated to providing the best possible care and service to you and regard your complete understanding our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept cash or check.

- Your insurance policy is a contract between you and your insurance. As a courtesy, we will file your primary insurance claim for you if you assign the benefits to the doctor, **however** we do not file secondary insurance claims. In other words, you pay the practice within a reasonable period; we will have to look to you for payment.

- We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.

- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be “not covered,” or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

- You must inform the office of all-insurance charges and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain electives surgical procedures that we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

- There is a service fee of \$25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Witness: _____ Date: _____

_____ Patient initials to indicate copy received.

SUMMARY OF NOTICE OF PRIVACY PRACTICES

*This summary is provided to assist you in understanding
the attached Notice of Privacy Practice*

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Use and Disclosures of/ Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Use and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization.

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects of incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To receive notice of your privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

ACKNOWLEDGMENT 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.

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature