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A STEP IN THE RIGHT DIRECTION

Information To Become part of Your Confidential Medical Record		Print Legibly	Today's Date
First Name	**Middle Initial**	**Last Name**	
Patient's Age	**Patient's Date of Birth**	**Sex** ○ Male ○ Female	**Marital Status** Single - Married – Divorced – Separated – Widow
Patient's Phone # **Home** **Work** **Cell** **Email**		**Spouse's Name** **Date of Birth** **Phone Number**	
Patient's Mailing Address (NO PO BOX). Include Apt. Route, or Street **City, State** **Zip Code:**		**Health Insurance Company & P.O Box Address**	
Patient's Mailing Address If different then address listed above **City, State** **Zip Code:**		**Insurance Policy Holder (as it appears on card)** **Policy Holder's DOB**	
Patient's Primary Care Physician		**Date Last Seen by Primary Care Physician**	
Primary Care Physician's Phone #		**How did you hear about us?**	
Pharmacy Name **City** **Phone Number**		***Occupation*** ***# of Years at Occupation:***	

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Name, address & phone number of relative or friend NOT living with you in case of an emergency (Information is REQUIRED by doctor)
Name **Address** **City, State, Zip Code:** **Phone Number**

Complete This Section ONLY if Patients is a Minor		
Mother's Name **First Middle Last** **Mother's Address**		**Marital Status** **Single Married** **Divorced Separated Widowed**
Mother's Phone # **Home** **Work** **Cell**	**Address of Mother's Employer**	**Mother's Birthday (mm/dd/yy)**
Father's Name **First Middle Last** **Father's Address**		**Marital Status** **Single Married Divorced Separated Widowed**
Father's Phone# **Work** **Cell**	**Address of Father's Employer**	**Father's Birthday**

_____ _____

(Patient's Name **(Today's Date)**

What and where is your primary foot or ankle problem?

_____

When did you first notice the problem?

_____

Have you ever had treatment for this problem, and by whom?

_____

What is your Weight _____ Height _____ Shoe Size _____

Allergies? Are you allergic or sensitive to any medications/agents?

_____

☐ I am NOT currently allergic to anything

Please list the names and dosages of any medications which you are now taking:

_____

_____

_____

☐ I am NOT currently taking any medications

Have you ever or are you currently being treated for any of the following (please check box if answer is **YES**)

☐ AIDS
☐ Arthritis
☐ Asthma or short of Breath
☐ Bleeding Disorders
☐ Cancer
☐ Cerebral Palsy
☐ Chicken Pox
☐ Cystic Fibrosis
☐ Diabetes
☐ Epilepsy
☐ Gout
☐ Heart Trouble
☐ High Blood Pressure or Tension
☐ Implants
☐ Keloid Scars
☐ Kidney Disease
☐ Liver Disease or Hepatitis
☐ Measles
☐ Multiple Sclerosis
☐ Mumps
☐ Neurological Diseases
☐ Numbness of Legs or Feet
☐ Phlebitis
☐ Polio
☐ Poor Circulation
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Strokes
☐ Swelling of Ankle or Feet
☐ Thyroid Problems
☐ Ulcers
☐ Varicose Veins
☐ Whooping Cough
☐ Sweaty or smelly feet
☐ Dry or cracked heels
☐ Pain from neuropathy
☐ Aching foot
☐ Other _____

_____ _____

(Patient's Name) **(Today's Date)**

Previous Hospitalization and Surgeries, Please state nature of the problem or surgery and the year it occurred.

_____
_____
_____
_____

Has any blood relative ever had: (Check YES and list who)

ILLNESS	**YES**	**If YES list who (father, mother, etc.)**
Alcoholism		
Bleeding Tendencies		
Cancer		
Diabetes		
Foot Problems (ie bunions, etc.)		
Gout		
Heart Disease		
Hepatitis/Liver Disease		
High Blood Pressure		
Kidney Disease		
Neurological Disease		
Rheumatoid Arthritis		
Stroke		
Thyroid Disease		
Tuberculosis		

Social History (Check appropriate column to describe use of the following)

Product	**Never**	**Rarely**	**Occasional**	**Daily**
Alcohol				
Aspirin				
Coffee or Tea				
Sleeping Pills				
Tobacco				
Tranquilizers				
Other _____				

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Attention Medicare Patients

Please note that your Medicare deductible and coinsurance are due ***on the date of service***. We file all claims and the amount will go towards your $183 Medicare deductible. However, understand that your deductible is still due if it has not been met to date. Medicare will ***NOT*** cover any charges until the $183 calendar year deductible has been paid. As a courtesy we verify if your secondary insurance picks up your Medicare deductible and or coinsurance, and will inform you of such information. In addition, please understand that this is in line with the financial policy that was signed and agreed to on your first day of visit. If you have any questions please feel free to ask our staff.

Note: As of 1/1/17 Medicare deductible increased to $183

Patient Signature: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf of Dr. Silvers for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing or the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary (Patient) Signature Date

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Read the following pages CAREFULLY, SIGN and DATE each page

1. Authorization to Release Medical Information:

I authorize release of medical information necessary to process the insurance claim(s) and permit the following to be used in place of this original document for all federal, state, commercial, compensation, or liability insurance claims:

1. A photocopy or other facsimile reproduction of this authorization, or
2. Use of a computer to indicate my signature is on file at the clinic, and/or
3. Use of a computer to electronically transmit my claim for processing.

2. Authorization to Assign Medical Benefits to Clinic:

I certify that information provided relative to injury, illness, and insurance coverage is both true and correct. **I will notify the clinic of any changes to the information supplied**. I authorize payment of insurance benefits or proceeds from any liability claim or legal/court settlement to be assigned to the physician of this clinic to the extent that their charges are paid in full.

3. Acknowledgement of Insurance Limitations:

Most insurance carriers require a written referral from a primary care physician in advance of services (office visits, surgery, diagnostic tests, etc.). Patients are responsible for:

1. Obtaining physician referrals
2. Contacting their insurance carrier to verify benefits in advance of service
3. Patient's are also responsible for non-covered services, deductibles, co-insurance, and any penalties imposed by their insurance company on our doctor for seeing patients out of network.
4. **Copayments, co-insurances, and deductibles are due at the time of service.**

4. Acknowledgement of Payment Responsibility:

Payment for medical services is between the clinic (doctor) and the patient. Payment is due in full according to the terms of this Clinic financial policy. Therefore, I understand that this Clinic cannot accept the responsibility for collecting or negotiating settlement on any disputed:

1. Health insurance claim
2. Accidental injury/illness liability claim
3. Claim where patient is/will be represented by an attorney
4. Claim to be settled in a court of law.

_____

Print Name

_____ _____

Patient or Guardian Signature Date

Payment Policy

Thank you for choosing Advanced Foot and Ankle Center as your foot care provider. We are committed to providing you with quality and affordable health care.

Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

As of January 1, 2010 the office of Advanced Foot & Ankle Center is accepting checks. We charge a return check fee in the amount of $50.00. Out of town checks will not be accepted.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at the time of service. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit and services provided is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payment, Co-insurance, and Deductible. All co-payment, co-insurance, and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurances, and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment, co-insurance, and/or deductible at each visit.

3. Proof of Insurance. All patients must complete our patient information form prior to seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card in order to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim.

4. Referrals If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become non refundable if the proper referral is not obtained by then.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 60 days past due, you will receive a letter requesting immediate payment. A re-billing charge of $10.00 per month will accrue on all accounts over 60 days past due. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to collections, as well you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed Appointments. Our policy is to charge $25.00 for missed appointments or $50.00 for a missed procedure appointment if not canceled within a reasonable amount of time (24 hours). These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

Our fees are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.
I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Patient or Guardian Signature Date

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMOs and PPOs, managed care organizations, IPAs, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medial records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or payment thereof.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak to the Office Manager to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Practices is effective as of April 14, 2003.

_____ _____

Patient or Guardian Signature Date

List family/friends that we may discuss your medical/financial matters with:

_____

_____

_____

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Laboratory Services

Unless you instruct us otherwise, any specimens taken will be sent to **Bako Pathology Services**. **Bako** accepts all major insurance plans. Please be advised since we do send all specimens to an outside lab we do not charge for the actual test. There is a possibility you will receive a bill from Bako if the services are not covered by your insurance.

When you are sent to an outside lab for blood draw, we will send you to either **Lab Corp** or **Quest**. Again, since we do not charge for the actual test there is a possibility you could receive a bill from **Lab Corp** or **Quest** if the services are not covered by your insurance.

We will make every effort to notify you of your results whether they are normal or abnormal. Please allow 5-7 business days for results. If you have not received notification of your results within a week, please call the office.

I have read this document and understand the policies and my financial responsibility.

_____

Print Name

_____ _____

Patient or Guardian Signature Date