Foot & Ankle Physicians of Ohio

Welcome to our office! We are very pleased to have you with us.
Please fill in all the appropriate blanks below.
This information is important for your health and our records.
It also helps in expediting your insurance payment.
If you need help please do not hesitate to ask.

PLEASE HAVE YOUR INSURANCE CARD AND PHOTO ID AVAILABLE FOR THE RECEPTIONIST TO COPY.

(PLEASE PRINT)

PATIENT NAME: LAST	FIRST	MI	SEX	BIRTH DATE	AGE

HOME ADDRESS: STREET APT.#	CITY	STATE	ZIP CODE

HOME TELEPHONE #	CELL PHONE #	MARITAL STATUS	SOCIAL SECURITY NUMBER

NAME OF SPOUSE/PARENT GARDIAN	SPOUSE'S/GARDIAN'S SOCIAL SECURITY NUMBER	SPOUSE'S/GARDIAN'S BIRTH DATE	SPOUSE'S/GARDIAN'S CELL PHONE #

EMERGENCY CONTACT PERSON & TELEPHONE #	PATIENT'S EMAIL ADDRESS

PATIENT'S EMPLOYER (OR FATHER'S)			PATIENT'S EMPLOYER (OR MOTHER'S)		
BUSINESS ADDRESS			BUSINESS ADDRESS		
CITY	ZIP	BUS. PHONE #	CITY	ZIP	BUS. PHONE #
OCCUPATION			OCCUPATION		

PRIMARY INSURANCE COMPANY			SECONDARY INSURANCE COMPANY		
ADDRESS			ADDRESS		
SUBSCRIBER'S NAME (IF NOT THE PATIENT)		RELATIONSHIP TO PATIENT	SUBSCRIBER'S NAME (IF NOT THE PATIENT)		RELATIONSHIP TO PATIENT
ID NUMBER	GROUP NUMBER	DATE OF BIRTH	ID NUMBER	GROUP NUMBER	DATE OF BIRTH

FAMILY PHYSICIAN	TELEPHONE #	DID THEY REQUEST YOU BE SEEN IN OUR OFFICE
FORMER PODIATRIST		WHAT WERE YOU TREATED FOR?

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? (PLEASE LIST THEIR NAME)

PHYSICIAN REFERRAL_____ WEB-SITE_____ INSURANCE_____ SIGN_____ MEDIA_____

STAFF MEMBER _____ PATIENT/FRIEND _____ MEDICAL RESISDENT _____

I HEREBY GIVE MY PERMISSION TO THE DOCTOR OF FOOT & ANKLE PHYSICIANS OF OHIO TO EXAMINE, PHOTOGRAPH, ADMINISTER TREATMENT AND PERFORM SUCH MINOR OPERATIVE PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FOOT PROBLEM.

SIGNATURE _____ DATE _____

PARENT'S SIGNATURE _____ DATE _____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIM. I AUTHORIZE PAYMENT OF MEDICAL/SURGICAL BENEFITS DIRECTLY TO DR. ELIZABETH HEWITT

SIGNATURE_____ DATE _____

IS THE REASON FOR YOUR VISIT TODAY RELATED TO A WORK INJURY / WORKERS COMPENSATION CLAIM? IF YES, CLAIM # _____

DO YOU HAVE A 1ST REPORT OF INJURY? YES / NO NAME OF PHYSICIAN OF RECORD_____ DATE OF INJURY_____

Name of Patient: _____

Date: _____

Why are you seeing the Doctor today? _____

_____

Do you have any medication allergies? Yes or No To what? _____

Do you or have you ever smoked? Yes or No If so, how long? _____
If you quit, how long ago? _____

Do you have an alcohol or drug addiction? Yes or No Which? _____

Do you have high blood pressure? Yes or No

Do you have Diabetes? Yes or No Do you use Insulin? Yes or No

Have you ever had a heart attack or heart surgery? Yes or No When? _____

Do you have Hepatitis A, B, or C? Yes or No Which? _____

Do you have HIV or AIDS? Yes or No

Have you ever had a blood clot? Yes or No

Please list any foot or ankle surgeries:

Please List any Medications:

Preferred Pharmacy Name: _____Address:_____
Telephone Number: _____

Is there any other information you would like us to know or is there anything you would like to discuss with your doctor privately? Yes or No _____

Are you Pregnant? Yes or No

Shoe size_____ Height_____ Weight _____

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

_____	_____	_____	_____
Name of Patient	**Date of Birth**	**Signature of Patient/Parent/Guardian**	**Date**

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Print Name: _____ **Print Name:** _____
Print Name: _____ **Print Name:** _____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number: **Written Communication Address:**

_____ _____

____OK to leave message with detailed information ____OK to mail to address listed above
____Leave message with call back numbers only ____E-mail me at: _____
Other: _____

IV. The following person(s) <u>are not authorized</u> to receive my Patient Health Information (PHI):

Print Name: _____ **Print Name:** _____

V. The HIPAA Privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary health care activities related to providing patient treatment, obtaining payment for its services or its internal operations. Also, the Practice does not have to account for disclosures for which I have executed an Authorization permitting disclosures of my PHI.

1. The above authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive healthcare at the Practice.
2. These Authorizations may be revoked at any time by notifying the Practice in writing at the Practices mailing address marked to the attention of "HIPAA Compliance Officer."
3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
4. I may see and copy the information described in this form, if I ask for it, and I will get a copy of this form after I sign it.
5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.
6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

_____	_____	_____
Name of Patient (Printed)	Signature of Patient	Date

Financial Policy for Foot & Ankle Physicians of Ohio

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans, however we encourage you to check with your insurance carrier to confirm our participation. We require that you bring your insurance card with you to each visit so that we may confirm your eligibility. If you do not present your card and it is determined that you do not have coverage, you will be responsible for the charges incurred at the time of the service. You are responsible for keeping the office informed as to any changes in your insurance contract or carrier information. Please be aware that your insurance policy is a contract between you and your insurance carrier. We are pleased to provide the service of submitting claims for our patients; however we remind you that you are ultimately responsible for payment of any services provided to you.

COPAYMENTS AND DEDUCTIBLES: Most insurance plans require that the insured patient pay a co-payment for office visits and other specified services such as x-rays and injections. Foot & Ankle Physicians of Ohio is **required** by the plans we contract with to collect your co-pay and any unmet deductible at the time of your service. Any questions you might have regarding co-payments and deductibles should be directed to your insurance company or your employer's human resources department. **Knowing your insurance benefits is your responsibility**.

MEDICARE: We are a participating Medicare provider. Medicare, as well as any secondary insurance, will be billed for you. Patients are responsible for paying their annual deductible if not previously met as well as any co-payments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to any secondary insurance after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

NON-COVERED SERVICES: Please be aware that some of the services you receive **may not be covered** or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payments of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow all guidelines of a managed care plan that may require when you visit a specialist, you must have a referral from your primary care physician **prior to seeking specialty care**. If your plan requires a referral, and if you do not have a referral from your primary care physician at the time of the visit, you will be financially responsible for all services due in full upon completion of the visit. You may also be given the option to reschedule your appointment.

CLAIM 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 in a timely manner. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance/deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case-by-case basis. We accept the following payment methods: Cash, Check, VISA/MasterCard/Discover, and HSA/HRA. An additional $25.00 will be added to your statement if your check is returned for insufficient funds. In the event your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

CHARGES YOU MAY INCUR: If we are asked to complete additional forms or reports for you, there will be additional charges. Form and report completion fees are collected when the request is made. These fees will **NOT** be billed to your insurance company. Additional charges will be assessed for the following: Disability Forms, FMLA forms, Copies of Medical Records, Returned Checks, Attending Physician Statement, Over-the-counter medical supplies, and Shoe Restocking.

DURABLE MEDICAL EQUIPMENT/CUSTOM ORTHOTICS: Durable Medical Equipment (DME) and custom orthotics may not be returned.

I have read and agree to abide by the above financial policy and have been given an opportunity to ask questions on any points that I did not understand. I agree to pay Step Lively Foot & Ankle Centers any balance unpaid by my insurance carrier for myself or the below named person.

ASSIGNMENT OF BENEFITS: I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Foot & Ankle Physicians of Ohio, all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or noncovered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the release of my medical information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

Patient's name (Printed): _____ **Patient's signature:** _____ **Date:** _____

FINANCIALLY RESPONSIBLE PARTY:

Print Name: _____ **Signature:** _____ **Relationship to Patient:** _____