Ankle & Foot Care Centers
PATIENT REGISTRATION FORM

Patient Information:

Today's Date: _____

Last Name: _____ First: _____ M.I. _____

Mailing Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home Phone #: (___) _____ Cell Phone #: (___) _____

E-mail Address: _____

Date of Birth: _____ Age: _____ SS#: _____

Sex (circle): Male Female Marital Status (circle): Married Single Divorced Widowed Separated

Height: _____ Weight: _____ Shoe Size: _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone #: (___) _____

Spouse or Parent (if patient is a minor):

Name: _____ Date of Birth: _____ SS#: _____

Relation to Patient: _____ Phone #: (___) _____

Emergency Contact:

Name: _____ Phone #: (___) _____

Relation to Patient: _____

Referral Information: How did you find out about us? (please check appropriate box) ○ previous patient

__Family/Friend
__Dr._____
__Hospital_____
__Insurance Book
__Newspaper Ad
__Phone Book
__Internet
__TV/Radio Ad
__Building Sign
__Other_____

Insurance Information (must be completed to bill insurance):

Name of Primary Insurance: _____(need copy of insurance card)
Name of Policyholder (person who actually has the insurance coverage): _____
Policyholder's Date of Birth _____Policyholder's SSN # _____
Patient Relationship to Policyholder: _____

Name of Secondary Insurance: _____(need copy of insurance card)
Name of Policyholder (person who actually has the insurance coverage): _____
Policyholder's Date of Birth _____Policyholder's SSN # _____
Patient Relationship to Policyholder: _____

Are you seeking this treatment for a Worker Compensation injury? Yes No

If "Yes" has your employer been notified? Yes No

Workman's Comp. Claim #: _____ Contact Person: _____

_____

Chief Complaint: What is the reason for the visit? _____

Duration of Problem: _____ Date of Injury: _____

Any Previous Treatment? Yes / No What type? _____ By Whom? _____

_____

Social History:

Tobacco Use:	Yes	No	Packs/day_____	# of years: _____
Alcohol Use:	Yes	No	Drinks/day_____	# of years: _____
Illicit Drug Use:	Yes	No	Type: _____	# of years: _____

Athletic Activities: _____

Past Medical History: Do you or have you had any problems with (check all that apply):

__Heart	__Circulation	__Thyroid	__Bladder
__Lungs	__Head	__Cancer	__Prostate
__Liver	__Eyes	__Diabetes	__Ovaries/Uterus
__Kidneys	__Ears	__Stomach	__Bones/Joints

__Other: _____

Past Surgeries/Hospitalizations: _____

_____

_____

Allergies & Reactions: _____

Family Physician: _____ Date Last Seen: _____

Pharmacy Name: _____ Zip Code: _____

Current Medications (Including prescriptions, over-the-counter, and vitamins):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Family Medical History: Please check (√) those family members that have any of the conditions listed below:

Condition	Mother	Father	Brother	Sister	Grandmother	GrandFather	Aunt	Unde	
Arthritis									
Asthma									
Cancer									
Diabetes									
Hemophilia									
Heart Disease									
High Blood Pressure									
Kidney Disease									
Liver Disease									
Low Blood Pressure									
Stroke									
Thyroid Disease									
Tuberculosis									
Other _____									

Signature on File & Permission to Treat:
I request that payments of authorized benefits be made on my behalf for any services furnished by **Ankle & Foot Care Centers.** I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent. I recognize my financial obligation of any co-insurance, co-pays, or deductibles and non-covered services that may be required. I give permission to Ankle & Foot Care Centers to examine, photograph, administer, and perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of foot and/or ankle problems for myself or as legal guardian for the patient.

Signed:_____ Date:_____
Patient or Legal Guardian

FINANCIAL POLICY
We are committed to providing you with the highest quality medical and surgical care. In return, we ask you to be equally committed to being fully responsible for paying our fees. Our goal is to maximize the quality of your care and minimize misunderstandings regarding fees and payments. **To ensure quality communication, it is the patient's and/or guardian's responsibility to inquire about fees/insurance coverage prior to any service being performed.** We accept many different insurance plans; however, all health plans are not the same and do not cover the same services. It is the policy of this office to help obtain insurance benefits regarding a patient's individual coverage of these items. This is a courtesy service which we are happy to provide; however, Ankle & Foot Care Centers is **NOT** held responsible for the accuracy of the information received. Information received by phone is not a guarantee of payment and if any doubt exists as to eligibility, it is highly recommended that you check your plan booklet or call your insurance plan for a detailed outline of your benefits.

-Managed Care/Private Insurance Patients

If you are in a managed care plan (e.g., HMO/PPO) with whom we participate, we abide by our contract with them. We will bill your insurance company; however, you are responsible for paying any co-pays, co-insurance, and deductibles required by your plan at the time of treatment.

-Medicare Patients

We accept assignment. This does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any co-payments, which are usually 20% of the allowed amount for an item or service.

-Uninsured Patients

A minimum payment of $65 is due at the time of service. Additional charges may apply.

-All Patients

For your convenience we accept: Visa, Mastercard, American Express, Discover, cash, or check. There is a service fee of $25 for all returned checks.

Please note: It is the responsibility of each patient to know their contract limitations. Specifically, if your policy requires a written referral prior to your visit, it is the patient's responsibility to obtain that referral, or have it sent to our office, prior to obtaining services from Ankle& Foot Care Centers.

Signed:_____ Date:_____
Patient or Legal Guardian

PRIVACY PRACTICES

Ankle & Foot Care Centers will use and disclose your health information for the following purposes: treating you, assisting other health care providers in treating you, allowing insurance companies to process insurance claims for services rendered, obtaining payment for services rendered to you, and for certain operational activities such as quality assessment, licensing, accreditation, and training of students. 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. If you have any questions, concerns, or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices provided to you.

Additional Disclosure Authority: In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below (please provide name & phone #):

Yes No Mother _____
Yes No Father _____
Yes No Sister _____
Yes No Brother _____
Yes No Spouse _____
Yes No Other _____

I acknowledge that I was provided a copy of the Notice of Privacy Practices, have read, or had the opportunity to read, and understand the Notice.

Signed: _____ Date:_____
Patient or Legal Guardian

Rev. 9/27/17b

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

MIPS Data Collection

Today's Date: _____

Patient Name: _____ Date of Birth: _____

In order to comply with governmental regulations, we need to obtain some additional health information from our patients. Thank you for taking the time to complete this brief form.

A. For All Patients:

1. What is Patient's Email Address:_____

2. Has the patient received a Flu Vaccine for the current season? _____Yes _____No

If "No", what was the reason the patient didn't obtain a flu vaccine:

_____ Patient has an Allergy

_____ Patient Declined/Did Not Want

_____ Vaccine Was Not Available

B. For Patients 18 years of age or older:

1. Has the patient used tobacco (in any form) one or more times within the last 24 month? _____ Yes _____No

2. Does the patient have diabetes? _____ Yes _____No

If "Yes", who is the physician that manages the patient's diabetes: _____

C. For Patients 65 years of age or older:

1. Does the patient have a living will or is there a person designated to make health care decisions on patient's behalf? _____ Yes _____ No,

If "Yes", who is the person: _____

Relationship to the person: _____

2. Have you ever had a pneumonia vaccination? _____ Yes _____ No

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For Internal Office Use:

Patient's Blood Pressure: _____ Patient's BMI: _____
Normal: 120/80 Normal: 18.5 to 24.9

Scan into Patient's Medical Record – Multi Media Files > MIPS-PQRS Folder Rev. 9/27/17