FOOT AND ANKLE CENTERS OF OHIO

- **PATIENT INFORMATION**

Name:____
Address:______________________________________
City:_________________State:__________Zip:_______
Social Security Number:___________________________
Age:________________Date of Birth:________________
Home Phone:______________Work Phone_____________
Cell Phone: _______________Email__________________
Place of Employment:______________________________
Address:______________________________________
City:_________________State:__________Zip:_______
Occupation:_____________________________________
Family Physician:________________________________
Gender: M F Marital Status: _________________
Race_________________Language __________________
Ethnicity: Hispanic/Latino Non Hispanic/Latino
Refuse to report

- **EMERGENCY CONTACT**

Name____
Address:______________________________________
City:___________________State:__________Zip:_______
Relationship:____________Home Phone:______________
Place of Employment:______________________________
Work Phone:____________ Cell Phone:_______________

IF THE PATIENT IS UNDER 18 YEARS OLD PLEASE COMPLETE THE FOLLOWING INFORMATION!

- **FATHER'S INFORMATION**

Name:____
Address:______________________________________
City:__________________State:____________Zip:_____
Home Phone:___________________________________
Business Phone:_________________________________
Date of Birth:______________SS#:__________________
Employer:_____________________________________
Employer's Address:______________________________
City:__________________State:____________Zip:_____

- **MOTHER'S INFORMATION**

Name:____
Address:______________________________________
City:____________________State:_________Zip:______
Home Phone:___________________________________
Business Phone:_________________________________
Date of Birth:_________________SS#:_______________
Employer:_____________________________________
Employer's Address:______________________________
City:____________________State:_________Zip:______

How did you hear about the practice? (circle one)

Internet/Google ___________ ***Friend/Family***___________

Doctor Referral (who?)_________________________

Facebook______________ ***Insurance Company***________

Other_______________________________________

ATTENTION: Please complete ALL of the questions on this form. If it does not apply to you please write N/A so we know that it does not apply to you. If you have questions, please ask the receptionist. Also, if you have any changes in medications or your medical history please inform a clinical employee.

- **WORKERS COMPENSATION**

Is this a work related injury?:_______________________
Will you be filing this with Workers Compensation?________
Date of Injury:_____________Claim Number:___________
Employer's Name and Address:______________________
____

- **PRIMARY (FIRST) INSURANCE** (still complete if you are filing worker's compensation)

Name of Insurance:_______________________________
Address:_______________________________________
City:________________State:___________Zip:________
Policy Holders Name:_____________________________
Policy Holders Home Address:______________________
Policy Holders Date of Birth:_______________________
Policy Holders Work Phone:________________________
ID/SS#:____

- **SECONDARY INSURANCE**

Name of Insurance:_______________________________
Address:_______________________________________
City:________________State:___________Zip:________
Policy Holders Name:_____________________________
Policy Holders Home Address:______________________
Policy Holders Date of Birth:_______________________
Policy Holders Work Phone:________________________
ID/SS#:____

- **THIRD INSURANCE**

Name of Insurance:_______________________________
Address:_______________________________________
City:________________State:___________Zip:________
Policy Holders Name:_____________________________
Policy Holders Home Address:______________________
Policy Holders Date of Birth:_______________________
Policy Holders Work Phone:________________________
ID/SS#:____

All professional services rendered are charged to the patient. The patient is responsible for fees regardless of insurance coverage or litigation. It is customary to pay for the services when rendered unless other arrangements have been made in advance. If we are a participating provider with your insurance company you are expected to pay your co-pay at time of service.

I hearby authorize FOOT AND ANKLE CENTERS OF OHIO to furnish information to your insurance carrier concerning my illness and treatments and I hearby assign to the physician (s) all payments for my medical services rendered to myself or dependents. I understand that I am responsible for any amount not covered by my insurance.

Signature:_____________________________________
Date:____

FINANCIAL POLICY

- Payment is due at the time services are rendered unless your insurance plan indicates an alternative method of reimbursement. For your convenience, we accept cash, check, money order, Visa, Discover and Master Card. This policy applies to all of our patients. Co-payments must be paid on the date service is given. Patients are responsible for deductible or charges not reimbursed at usual, customary and reasonable levels. Our office automatically files your insurance claims.

- There is a $25 charge on all returned checks. Past due balances are subject to a $2 billing surcharge per month.

- If your insurance requires a referral from your primary care physician in order for you to be seen by a specialist, our office must be given that referral by the day of your appointment. In the event that we do not receive the required referral, you will be asked for payment in full at the time service is rendered.

- We understand that unusual circumstances may arise and that payment in full at the time of service may not always be possible. Special payment needs should be discussed by the patient and the office manager.

- You will receive monthly statements unless your insurance coverage is National Footcare, Medicaid, Worker's Comp, and Medicare with a secondary coverage as Medicaid. If you have not made payment in full or made full financial arrangements with our office, your account will be reviewed for collection. Patients having health care insurance should remember that professional services provided are the patient's responsibility, not the insurance company.

AFTER 90 DAYS FROM EACH DATE OF SERVICES YOUR CLAIM WILL BECOME YOUR RESPONSIBILITY. YOU NEED TO CHECK WITH YOUR INSURANCE COMPANY PRIOR TO THAT DATE ON THE STATUS OF EACH CLAIM.

- Our office will file primary and secondary insurance forms for you as long as we have a copy of your current insurance cards in your chart.

- If you wish to file your own insurance, please notify our business department for instructions. If your insurance company requires that claims be submitted on special forms, you are responsible for notifying our office and providing the necessary forms.

- Certain services that may be necessary for your feet may not be covered by Medicare.

- In cases of divorce, the parent who brings the child/children in for treatment is responsible for payment and for collecting from the other parent or attorneys.

SPECIAL SUPPLIES AND ORTHOTICS

- Supplies that may be recommended as part of your treatment by your physician (i.e. crutches, braces, splints, etc.) must be paid for at the time they are received by the patient. Our office makes these supplies available to our patients as a convenience. However you are free to purchase them at your local pharmacy, brace or medical supply store. Special braces etc. that need to be ordered special for the patient must be paid in full before they are ordered.

- ORTHOTICS will not be ordered for a patient unless the patient has paid $100.00 prior to the casting. We expect that the balance is paid in full when the orthotics are fitted in the patients shoes. Medicare DOES NOT pay for orthotics.

DISABILITY FORMS and NO SHOW APPOINTMENTS

- Forms that need to be filled out for loans (i.e. car, house, etc.) for the patient will be charged $10.00 per form and must be paid before the form is completed. If a patient does not show up for an appointment and does not cancel prior to the time of the appointment $20.00 may be charged to the account.

COPYING OF RECORDS AND X-RAYS

- There may be a charge for copying of the patients chart and x-rays.

If you have any questions please call the Office Manager at 419-394-8664 or 1-800-664-9394 at the St. Marys office.

I have read FOOT AND ANKLE CENTERS OF OHIO's financial policy and understand my financial responsibility and agree to the terms in the Financial Policy.

Signature of Patient or Legal Guardian:_______________________________________ Date:____________________

(Revised 8/08)

Foot and Ankle Centers of Ohio, Inc.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, [name of patient] ______________________________, acknowledge and agree that I have reviewed and/or received a copy of Foot and Ankle Centers of Ohio, Inc.'s Notice of Privacy Practices.

With this consent, Foot and Ankle Centers of Ohio, Inc. may call my home or alternative location and leave a voice mail or in person in reference to treatment, payment and health care operations (TPO). I also consent to mail or email to my home or alternative location any items that assist in carrying out TPO.

With this consent, Foot and Ankle Centers of Ohio, Inc. has my permission to electronically exchange and/or retrieve medication history information with a Pharmacy.

I understand that my driver's license (photo ID) will be retained in my medical record and used for identification purposes.

This form allows you to designate family members, friends or other individuals to whom you authorize Foot and Ankle Centers of Ohio, Inc. to release Protected Health Information. I authorize the following person(s) involved in my care to receive medical information about me.

______________________________ ______________________
Patient Signature, Parent or Guardian, Patient Legal Representative Date

Name	Relationship to patient	Phone

FOR OFFICE USE ONLY:

Foot and Ankle Centers of Ohio, Inc. made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.

____

____

Employee: ______________________ Date: __________

Revised 5/12

PATIENT MEDICAL HISTORY

Patient's Name:________________________________ Age:____

Height:__________________ Weight:____________________ Shoe Size:_____________________________

What condition are you being seen for today?____

____

Where is it?____

How long have you had it?____

What started it or makes it worse?____

What makes it better?____

What treatment have you had?____

Goals of Treatment:____

Have you ever been treated by another podiatrist?____

If so, who, for what condition and when?____

____

MEDICAL HISTORY REVIEW: Do you have a history of any of the following?

___Diabetes ___Gout ___Arthritis ___Stroke
___High Blood Pressure ___Heart Problems ___HIV Positive ___Seizures
___Rheumatic fever ___Asthma ___Circulatory Problems ___Hepatitis/Liver Problems
___Cancer ___Phlebitis ___Glaucoma/Eye Problems
___Tuberculosis ___Kidney Disease ___Keloids ___Paralysis

Have you had any of the following conditions recently?:

___Currently Pregnant ___Excessive Bleeding ___Poor Healing ___Excessive Fatigue
___Anemia ___Large Weight Change ___Shortness of Breath ___Frequent Headaches
___Problems Hearing ___Sinus Problems ___Chest Pain ___Excessive Coughing
___Frequent Sore Throats ___Digestive Problems ___Stomach Ulcers ___Frequent Thirst
___Frequent Urination ___Leg Swelling ___Joint Pain or Stiffness ___Muscle Weakness
___Varicose Veins ___Leg Cramps ___Back Pain ___Skin Rashes
___Swollen Glands ___Thyroid Problems ___Immune System Problems
___Depression ___Frequent Anxiety or Psychiatric History
___Numbness or Neurologic Problems

Other problems or condition not listed above:____

____

Family doctor and other doctors are you currently seeing?:____

____

List all previous significant injuries (broken bones, sprains, etc.)____

____

SURGERY AND YEAR
List all previous surgeries:____

____

____

MEDICATIONS: Please list ALL: Including Aspirin/ Vitamins/ Minerals/ Herbs

MEDICATION	HOW OFTEN TAKEN	STRENGTH	WHY TAKING

NAME AND LOCATION OF PHARMACY: ____

ALLERGIES:
___Novacaine ___Aspirin ___Codeine ___Other Antibiotics___________
___Penicillin ___Iodine ___Metal ___ Latex ___Bananas
___Tape/Band-Aids ___Sulfa ___Other (food, fabric, etc.)___________________________

SOCIAL HISTORY:
Exercise, Sports, or Recreational Activities where you are on your feet_______________________________

Use of Alcohol: Never Occasional Moderate Daily How many? __________ Quit,when_________

Tobacco History: No Yes If yes, Type ______________ How much____________How long___________
Quit, when____________________________

Recreational/Street Drug Use: Never Currently Quit less than 3 years ago In the past only
If yes, Type _______________________________

FAMILY HISTORY: Please enter the relationship of the family member with the following
Diabetes ______________________ Stroke______________________ Seizures_______________________
High Blood Pressure____________________________ Heart Problems__________________________________
Tuberculosis(TB)________________ Asthma______________________ Circulatory Problems_______________
Foot Problems___________________ Cancer______________________ Phlebitis_________________________

Other problems or condition not listed above: ____

____

SIGNATURE:____ DATE:______________________________