ARKANSAS FOOT & ANKLE SPECIALISTS

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PATIENT INFORMATION

First Name: _____ Last Name: _____ MI: _____ Gender: __M __F

Suffix (Jr, Sr, III): _____ SS#: _____ Age: _____ Date of Birth: _____

Marital Status: __Married __Single __Domestic Partner __Divorced __Separated __Widowed __Minor

Address: _____City: _____ State: _____ Zip: _____

Home:(___) _____ Cell:(____)_____ Preferred Contact: __Home __Cell

May we leave detailed messages at that number? Yes No E-Mail:_____

Employed: __YES __NO Employer Name: _____ Occupation: _____

Emergency Contact: _____ Relation: _____ Phone#:(____) _____

NOTE: In order for us to file a claim on your behalf, this section must be completed in its entirety

RESPONSIBLE PARTY FOR ACCOUNT (IF DIFFERENT THAN PATIENT)

Name: _____ Relationship to patient: _____

Address: _____City:_____ State:_____ Zip:_____

Home:(____)_____ Cell:(____)_____ Email:_____

INSURANCE INFORMATION

Primary Insurance Name: _____ Plan Type: __HMO __PPO __Other: _____

ID #: _____ Group#: _____ Effective Date: _____

Policy Holder Name: _____Employer: _____Date of Birth:_____

Relationship to patient:_____

Secondary Insurance Name: _____ Plan Type: __HMO __PPO__ Other: _____

ID#: _____ Group#: _____ Effective Date: _____

Policy Holder Name: _____ Employer: _____Date of Birth:_____

Relationship to patient: _____

V**ISIT INFORMATION**

Please briefly describe the reason for your visit: _____

Which foot is this problem in? ____Left ____Right ____Both What size shoe do you wear? _____

How tall are you? _____ What is your current weight? _____

How did you find out about our practice? __Physician __Internet __Friend Other: _____

Whom can we specifically thank for your referral? _____

Primary Care Physician: _____ Physician Phone#:(___)_____

What pharmacy do you use? Name and street address _____

MEDICAL HISTORY (This MUST be completed, if it doesn't apply to you please put NA)

Medical conditions:_____

List any serious injuries and the age at which they occurred:_____
List any allergies and type of reaction:_____
_____
List all prior surgeries:_____
_____
List any medications you take on a daily basis:_____
_____
_____

Have you ever used:

Tobacco: _____ Past ____ Current, Frequency of use _____

Alcohol: _____ Past _____ Current, Frequency of use _____

Drugs: _____ Past _____Current, Frequency of use _____

FAMILY HISTORY: Is there a family history of any of these disorders?

Mother: ____TB ____Heart ____Migraines ____Cancer ____Kidney ____Spine ____Diabetes ____Gout ____Arthritis ____Hypertension ____Epilepsy ____Mental ____Allergies _____Other

Father: ____TB ____Heart ____Migraines ____Cancer ____Kidney ____Spine ____Diabetes ____Gout ____Arthritis ____Hypertension ____Epilepsy ____Mental ____Allergies _____Other

REVIEW OF SYSTEMS

Constitutional	○ Fever	○ Chills	○ Nausea	○ Vomiting
Head	○ Dizziness	○ Fainting	○ Headaches	○ Migraines

Respiratory	○ Cough	○ Difficulty Breathing	○ Shortness of breath	○ Wheezing
Cardiovascular	○ Chest Pain ○ Varicose Veins	○ Cramps in leg/Feet ○ Vascular Grafts	○ Leg or foot ulcers	○ Palpitations
Gastro-Intestinal	○ Constipation	○ Diarrhea	○ Excessive Thirst	○ Heartburn
Musculoskeletal	○ Arthritis ○ Muscle Pain	○ Back Problems ○ Stiffness	○ Joint Pain ○ Weakness	○ Muscle Cramps
Skin	○ Athletes Foot ○ Ingrown Nails	○ Dryness ○ Itching	○ Fungal Nails	○ Hives
Neurological	○ Burning ○ Tremors	○ Fainting	○ Numbness	○ Tingling
Hematological	○ Anemia	○ Bleeding Disorder	○ Bleeding Easily	○ Easy Bruisability
Genitourinary	○ Burning	○ Excessive Urination	○ Kidney Stones	

Signature: _____ Date: _____

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PRACTICE FINANCIAL POLICY

Thank you for choosing Arkansas Foot and Ankle Specialists as part of your health care team. We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. We ask that you take a few moments to read our Financial Policy and sign below. **By signing below, you are agreeing to these terms:**

1. You are ultimately responsible for payment of charges for services you receive from this practice including those covered by your insurance. As a convenience, this practice will submit claims for reimbursement with your insurance provider; however, all payment responsibility is ultimately yours.

2. If you have no insurance, you are responsible for all services rendered.

3. Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card.

4. It is your responsibility to know the specifics of your policy (referral requirements, in and out of network physicians and facilities, etc.). Most private insurance policy plans now have deductibles, copayments, co-insurances, maximums and limitations (out of pocket expenses).

5. **Immediate payment is expected at the time of service.** This may include a co-pay and additional payment if this practice determines that the cost of your visit today will not be reimbursed by your insurance provider**. This often happens if your deductible is not yet satisfied.**

6. Care estimates are not guaranteed to be reflective of final charges for your visit. Your insurance company will make a final determination as to how much you owe after the claim for your visit is processed.

7. If your annual out of pocket expenses have not been met, and if Arkansas Foot and Ankle Specialists is unable to estimate your care, you will be asked to pay a $125 deposit during your visit. This will be applied to your account and a statement will be sent reflecting any additional monies owed following response from your insurance carrier.

8. Should your account reflect a credit following final claim determination by your insurance company, Arkansas Foot and Ankle Specialists will issue you a check via mail within 30 days of our receipt of your final claim determination.

9. Ultimate payment by your insurance company cannot be guaranteed by our staff. If you have any concerns; we advise you to contact your insurance company.

10. We rely on you to inform us of all insurances in effect and to notify the office immediately of any changes with your insurance. If you do not inform us of changes, you will be responsible for the services rendered.

11. When multiple insurance policies exist, it is the patient's responsibility to inform us which policy is the primary plan. If we are not provided ALL insurance information at the time of service, you will be responsible for paying Arkansas Foot and Ankle Specialists directly and then submitting for reimbursement from your insurance company.

12. Past due accounts, more than 90 days, will be turned over to our collection agency and a $35 administrative fee will be added to the account balance.

13**. MISSED/CANCELED APPOINTMENT POLICY:** If you miss an appointment, or cancel an appointment less than 24 hours of the appointment time, you will be charged a $25 fee. **Missed appointment fees are the responsibility of the patient.**

I have read and understand the Financial Policy of Arkansas Foot and Ankle Specialists

Patient's Name (print)_____

Date of Birth_____

Patient's/Guardian's Name_____

Signature_____

Date:_____