ANKLE & FOOT
ASSOCIATES, LLC

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Gregory J. Kramer, D.P.M., FACFAS
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Eric G. Massa, D.P.M., FACFAS
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Nicole E. Wilson, D.P.M.
Robert D. Yant, D.P.M.

Welcome and thank you for choosing Ankle & Foot Associates, LLC. Please complete the enclosed information packet and bring the entire packet to your appointment. Please make every effort to have your paperwork completed to bring with you to the appointment. We will need a photo ID and a copy of your insurance information at the appointment as well.

If for some reason you are unable to complete your paperwork we ask that you come in for your appointment twenty minutes earlier for assistance. If you are in need of assistance completing the paperwork we ask that you **bring a list of your current medication with you to your appointment.** Please make every effort to complete this before your appointment.

Once again, we appreciate you choosing Ankle & Foot Associates, LLC, we look forward to seeing you at your appointment.

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REGISTRATION FORM

(Please Print)

Primary Care Physician: | Date Last Seen: _____ Pharmacy _____ Today's Date _____

PATIENT INFORMATION

Patient's last name: First: Middle: | ☐ Mr. ☐ Mrs. | ☐ Miss ☐ Ms. | Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Widow ☐

Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | (Former name): | Birth date: | Age: | Sex: ☐ M ☐ F

Street address: | Social Security #: | Home phone #: ( ) Cell Ph. #: ( )

P.O. Box: | City: | State: | Zip Code:

Occupation: | Employer: | Employer phone #: ( )

Chose clinic because/referred to clinic by (Please check one box)

☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Other family members seen here:

Physician Referral: No _____ *Yes* _____ *Physician* _____ *Ph#* _____

INSURANCE INFORMATION

(Please give your insurance card and photo ID to the receptionist)

Person responsible for bill: | Birth date: | Address (If different) | Home phone no.: ( )

Is the person a patient here? ☐ Yes ☐ No

Occupation: | Employer: | Employer address: | Employer phone no: ( )

Is the patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance | ☐ BCBS | ☐UHC | ☐Principal | ☐ Aetna | ☐ 1st Health

☐ Medicare | ☐ Medicaid | ☐ Supplement | ☐ Worker's Compensation | Other:

Subscriber's name: | Subscriber's S.S. no: | Birth date: | Group #: | Policy #: | Co-payment: $

Patient's relationship to subscriber: | ☐ Self | ☐ Spouse | ☐ Child | ☐ Other

Name of secondary insurance (If applicable): | Subscriber's name: | Group no.: | Policy no.:

Patient's relationship to subscriber: | ☐ Self | ☐ Spouse | ☐ Child | ☐ Other

Name of local friend or relative (not living at same address): | Relationship to patient | Home phone no.: ( ) | Work phone no.: ( )

Patient/Guardian signature _____ Date _____

Would you like for us to leave a message? If so, what number _____

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PLEASE COMPLETE THE FOLLOWING IF THE PATIENT IS A CHILD

Name_____ Date of Birth_____

FATHERS

Name_____ Date of Birth_____

Address _____ Phone _____

City, State, Zip _____ SS# _____

_____

MOTHERS

Name_____ Date of Birth_____

Address _____ Phone _____

City, State, Zip _____ SS# _____

_____

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Patient Medical History

What is the primary reason for your visit today: _____

_____

Family Doctor: _____ **Date Last Seen:** _____

Which LOCAL Pharmacy do you use: _____

Do you smoke? ☐ No ☐ Yes How much? _____ Drink Alcohol? ☐ No ☐ Yes How much? _____

Is there a family history of: Heart Disease _____ Cancer _____ or Diabetes _____

Do you exercise on a regular basis? ☐ No ☐ Yes

Shoe Size: _____ Weight: _____ Height: _____

Do you take regular medications? ☐ No ☐ Yes; *If Yes, please list on the attached form.*

Are you allergic to any medications? ☐ No ☐ Yes; *If Yes, please list on the attached form.*

Please list all previous surgeries and dates: _____

_____

_____

Please list any other problems for which you have a physician that we should be aware of: _____

_____

_____

PLEASE CHECK ALL THAT APPLY

____Diabetes Type I or II
____Hepatitis
____Stomach Ulcers/Hernia
____Chronic Cough/Wheezing/Asthma
____High Cholesterol
____COPD
____Tuberculosis
____Kidney Stones or Infections
____Are you on Blood Thinners?
____Anemia
____Bleeding or clotting problems

_____Heart Disease
_____High Blood Pressure
_____Heart Attack
_____Seizures
_____Arthritis
_____Thyroid Problems
_____Depression/Bipolar
_____Cancer
_____HIV/AIDS
_____Headaches
_____Stroke

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

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Patient Name: _____ Account Number:_____ Date: _____

ALLERGIES: _____

_____

MEDICATION	DOSAGE

Verified By: _____

ANKLE & FOOT ASSOCIATES, LLC

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing you with the, best possible medical care. In order to achieve this goal, we need your assistance, and your understanding of our payment policy. Please Initial each section indicating you have read and understand this Policy.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED
We accept cash, personal checks, Matercard and Visa. Returned checks are subject to a service charge of $20.00 or 5% of the face value of the check, whichever is greater, and you will lose your privilege to write checks in our office.

CANCELED APPOINTMENTS - Patients who do not cancel appointments will be charged an office visit after the third no-show.
MEDICARE - Your deductible and 20% of the allowable charges are due at the time of service. If we do not know the allowable charge for a specific service, we will bill you after Medicare pays. Please bring your Medicare Explanation of Benefits showing you have met your deductible.
WORKERS' COMPENSATION - We will call your employer to authorize your visit prior to your appointment. We will file with your company's insurance. In the event you fail to prosecute the claim for Worker's Compensation for this illness or condition, or it is determined by the Worker's Compensation board that the illness or condition is not a result of a compensable Worker's Compensation case, you agree to pay the usual and customary fees for services rendered to you in this case.
CHILDREN OF DIVORCED PARENTS - PAYMENT IS DUE AT THE TIME OF SERVICE no matter who is responsible by order of the divorce decree. The person presenting the minor child for treatment is responsible for any charges incurred.
FINANCIAL AGREEMENT - We will gladly discuss your proposed treatment and do our best to answer any questions to your insurance. You must realize, however that:

1. Your insurance is a contract between you, your employer, and the insurance company. we are not a party to that contract. We charge what is Usual & Customary for our area. You are responsible for payment regardless. of any insurance company's arbitrary determination of usual & customary rates.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (e. g., orthotics)
3. We will file a claim with your insurance company as a courtesy to you. Any charges that have not been paid after 90 days will automatically be due and payable by you. Any payments received by the insurance company after that date will be refunded to you, providing there was a zero balance on the account.

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.** On any balance on your account after 90 days, Including those that Insurance has not paid, collection action will be taken. We realize that emergencies do arise and may Affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the timely management of your account. If it becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable attorney's fees, whether suit is filed or not.

If you have any questions about the above information,or any uncertainly regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I will pay my co-payment / deductible amount today by _____ Check____ Cash _____Credit Card.

I have read and understand the above Financial Policy.

_____ _____
Signature Date

_____ _____
Witness Date

Ankle & Foot Associates, LLC

Name: _____ DOB _____

AUTHORIZATION

I, the undersigned certify that I (or my dependent) has insurance coverage as listed above and assign directly to Ankle & Foot Associates, LLC. I understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for payment of co-pays, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize Ankle & Foot Associates, LLC, to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

X Signature _____ Date _____

Are you the Guarantor? Yes ___No ___ If not please see receptionist.

CONSENT FOR TREATMENT

Having voluntarily presented myself (or my dependent) Ankle & Foot Associates, LLC, I acknowledge recognition of the fact that the evaluation and treatment received, advised or deemed necessary, to be the judgment of the Physician.

X Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (HIPPA)

By signing this form, you acknowledge that Ankle & Foot Associates, LLC, has offered or given to you a copy of its Privacy Notice, which explains how your, health information will be handled in a various situation. We must attempt to have you sign this form on your first date of service with us after April 14, 2003. This includes the situation where your first date of service occurred electronically. If your first date of service with us was due to an emergency, we must attempt to give you this notice and get your signature acknowledging receipt of this notice as soon as possible after the emergency.

☐ I have received a copy of the Privacy Notice of Ankle & Foot Associates, LLC.

☐ Ankle & Foot Associates, LLC< has offered me a copy of the Privacy Notice which I have declined and has given me the chance to discuss my concerns and questions about the privacy of my health information.

X Signature _____ Date _____

ADDITIONAL PERSON(S) AUTHORIZED TO MAKE THE USE OR DISCLOSURE OF MY MEDICAL HISTORY

We at Ankle & Foot Associates, LLC, value and do everything in our power to protect your privacy. Your medical information will not be given to any individual (Including spouses, parents, children, or any significant others without your written consent). If you want anyone other than your referring physician to have access to your medical information please list their name, address, relation, and phone number below. (Note: Uses and disclosures may be permitted without prior consent in an emergency.)

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

X Signature _____ Date _____

☐ **This will never expire** ☐ **This will expire on _____**

The staff of Ankle & Foot Associates, LLC should complete this section if Acknowledgement Form is not signed by the Patient:

1. Does the patient have a copy of the Privacy Notice? **Yes__No __**
2. Please explain why the patient was unable to sign an acknowledgement form and our efforts in trying to obtain the patient signature: _____

Employee Signature _____ Date _____

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Ankle and Foot Associates is now offering our patients easy and private access to their medical information online, so that you can view your personal health record whenever and wherever you have access to the internet. To gain access to our secure server on Patient Portal and become web-enabled, simply sign-up by providing us with a personal (non-work) e-mail address.

Patients Name DOB:

_____

E-Mail Address:

_____