

**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 us?*

*Doctor referral* \_\_\_\_\_

*Newspaper Phone Book Health Fair Friend/Relative*

*Website Business Card Past Patient TV Radio*

*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 hereby authorize FOOT AND ANKLE CENTERS OF OHIO to furnish information to your insurance carrier concerning my illness and treatments and I hereby 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 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 05/14)

**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

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Phone

\_\_\_\_\_  
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: \_\_\_\_\_

**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?

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Gout           | <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Seizures                 |
| <input type="checkbox"/> Rheumatic fever     | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Circulatory Problems  | <input type="checkbox"/> Hepatitis/Liver Problems |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Phlebitis      | <input type="checkbox"/> Glaucoma/Eye Problems |   |
| <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Keloids               | <input type="checkbox"/> Paralysis                |

Have you had any of the following conditions recently?:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Currently Pregnant              | <input type="checkbox"/> Excessive Bleeding                      | <input type="checkbox"/> Poor Healing            | <input type="checkbox"/> Excessive Fatigue  |
| <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Large Weight Change                     | <input type="checkbox"/> Shortness of Breath     | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Problems Hearing                | <input type="checkbox"/> Sinus Problems                          | <input type="checkbox"/> Chest Pain              | <input type="checkbox"/> Excessive Coughing |
| <input type="checkbox"/> Frequent Sore Throats           | <input type="checkbox"/> Digestive Problems                      | <input type="checkbox"/> Stomach Ulcers          | <input type="checkbox"/> Frequent Thirst    |
| <input type="checkbox"/> Frequent Urination              | <input type="checkbox"/> Leg Swelling                            | <input type="checkbox"/> Joint Pain or Stiffness | <input type="checkbox"/> Muscle Weakness    |
| <input type="checkbox"/> Varicose Veins                  | <input type="checkbox"/> Leg Cramps                              | <input type="checkbox"/> Back Pain               | <input type="checkbox"/> Skin Rashes        |
| <input type="checkbox"/> Swollen Glands                  | <input type="checkbox"/> Thyroid Problems                        | <input type="checkbox"/> Immune System Problems  |   |
| <input type="checkbox"/> Depression                      | <input type="checkbox"/> Frequent Anxiety or Psychiatric History |  |   |
| <input type="checkbox"/> 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

| <u>MEDICATION</u> | <u>HOW OFTEN TAKEN</u> | <u>STRENGTH</u> | <u>WHY TAKING</u> |
|-------------------|------------------------|-----------------|-------------------|
|                   |                        |                 |                   |
|                   |                        |                 |                   |
|                   |                        |                 |                   |
|                   |                        |                 |                   |
|                   |                        |                 |                   |
|                   |                        |                 |                   |
|                   |                        |                 |                   |
|                   |                        |                 |                   |
|                   |                        |                 |                   |
|                   |                        |                 |                   |

**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: \_\_\_\_\_