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 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 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: _____

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:_____