Advanced Foot & Ankle Clinic Registration Form

Patient Information

Patient's Legal Name _____
Last Name First Name Initial Prefered Name

Date of Birth _____/_____/_____ Age____ Sex_____ Social Security #_____

Race □White □Asian □African American Other_____ □Single □Married □Widowed

Ethnicity □Hispanic or Latino □Not Hispanic or Latino □Separated □Divorced □Other

Primary Language □English Other: _____

Phone 1 _____ □Home □Cell □Work Phone 2 _____□Home □Cell □Work

Email_____

Home Address _____

City_____ State _____ Zip Code _____

Mailing Address (if different) _____

City_____ State _____ Zip Code _____

- -

Employed By: _____ Work Phone _____

Occupation: _____

- -

Spouse's Name _____ Birthdate _____/_____/_____
Last Name First Name

Spouse Employed By:_____ Phone _____ □Home □Cell □Work

FOR PATIENTS UNDER THE AGE OF EIGHTEEN (18) YEARS ONLY

Name of Father _____ Soc Sec #_____

Birthdate_____/_____/_____ Employed By: _____ Phone_____

Name of Mother _____ Soc Sec #_____

Birthdate_____/_____/_____ Employed By: _____ Phone_____

Guarantor

Person(s) Responsible for Account (if different than patient or parents listed above)

_____ Phone: _____
Last Name First Name Relationship: _____

_____
Address City State Zip

Insurance

Primary Insurance Company_____ Subscriber: _____

Birthdate of Subscriber _____ Relationship: _____

- -

Secondary Insurance Company_____Subscriber: _____

Birthdate of Subscriber_____ Relationship:_____

- -

Is this a work or auto related injury? □Yes □No If yes, date of injury _____

Insurance Company _____ Claim Number _____

Contact Person _____ Phone Number _____

Misc

How did you hear about us?

□Family □Friend □Doctor □Internet □Social Media □Radio □News/Article □Word of Mouth □Other_____

Name of Person/Doctor referring you: _____

Your Medical History

Primary Care Doctor_____ Last Examination_____
Address or Clinic Name_____ Phone_____

1. Do you currently have any of the following symptoms?

Fatigue □Yes □No	*Weight Loss* □Yes □No	*Nose Bleeds* □Yes □No	*Depression* □Yes □No
Chills □Yes □No	*Sinus Problems* □Yes □No	*Shortness of Breath* □Yes □No	*Nausea* □Yes □No
Cough □Yes □No	*Chest Pain* □Yes □No	*Heart Murmur* □Yes □No	*Heartburn* □Yes □No
Hearing Loss □Yes □No	*Leg Cramps* □Yes □No	*Excessive Thirst* □Yes □No	*Fever* □Yes □No
Joint Pain □Yes □No	*Abdominal Pain* □Yes □No	*Excessive Hunger* □Yes □No	*Swelling* □Yes □No
Numbness □Yes □No	*Nervousness* □Yes □No	*Urinary Problems* □Yes □No	*Back Pain* □Yes □No
Skin Rashes □Yes □No	*Poor Vision* □Yes □No	*Bleeding Excessively* □Yes □No	*Weakness* □Yes □No
		Skin Lesions □Yes □No	

2. **Allergies:** □None □Adhesive Tape □ Latex □Sulfa □Aspirin □Penicillin □Codeine □Iodine □Vicodin
□Others: _____

3. **Medications & Dosages**: □I do not take any medications □List Attached
Where is your preferred pharmacy? _____ City _____

Medication	**Dosage**	**Reason**

5. Do you or a family member have a history of the following problems? (**S=Self, F=Family N=None**)

Diabetes	S	F	N	*Heart Problems*	S	F	N	*Gallbladder*	S	F	N
Stroke	S	F	N	*Blood Clots*	S	F	N	*Stomach Ulcer*	S	F	N
Hepatiis	S	F	N	*Kidney/Bladder*	S	F	N	*Arthritis*	S	F	N Type: _____
Asthma	S	F	N	*Gout*	S	F	N	*High Blood Pressure*	S	F	N
Glaucoma	S	F	N	*Anemia*	S	F	N	*Epilepsy/Seizure*	S	F	N
Thyroid	S	F	N	*Foot Problems*	S	F	N	*Cancer*	S	F	N
Lung	S	F	N	*Liver Problems*	S	F	N	*Other* _____			

6. Have you had any prior hospitalizations and/or surgeries? Please list, including dates _____
_____
_____

7. Do you require administration of an antibiotic prior to a procedure? □Yes □No

8. Are you diabetic? □Yes □No If yes, (circle) Type I Type II A1c_____

9 Women, are you pregnant? □Yes □No

10. Have you ever smoked? □Never □Former □Currently If yes, how often:_____ □Chewing Tobacco

11. Alcohol Consumption: □Yes □No If yes, how often: □Rarely □Occasionally □Socially □Moderately □Daily

12. Illicit/Illegal Drug Use: □Yes □No History of drug, alcohol, chemical abuse: □Yes □No

13. Height_____ Weight_____ Shoe Size_____

14. Exercise/Athletic Activities: _____

Your Visit

15. What is your reason for today's visit? □Left □Right □Toe □Foot □Ankle
_____
_____

16. On a scale of 1-10, rate your pain; 1 = Minimal & 10 = Extreme:

☺ 1 2 3 4 5 6 7 8 9 10 ☹

17. What have you tried to remedy the situation? Please include any self treatment(s) or treatment by another physician

Patient's Name _____
Last Name First Name Initial

Assignment & Release of Information

INDIVIDUAL INFORMATION DISCLOSURE RELEASE

Your privacy is important to us, and we want to protect it as much as possible. By signing this form, you authorize Advanced Foot & Ankle Clinic to disclose information as requested to the individuals you list below. This information may include, but is not limited to, verbal or written information relating to diagnosis and treatment, and billing information.

Write the names of the person(s) you are authorizing us to discuss your information with:

Patient's Name _____ _____
Last Name First Name Initial Relationship

Patient's Name _____ _____
Last Name First Name Initial Relationship

This authorization may be revoked at any time . Revocation must be made in writing to Advanced Foot & Ankle Clinic, at 803 E School St, Owatonna, MN 55060. I understand that if this information is disclosed to a thrid party, the information may be redisclosed by the person that receives the information and may no longer be protected by Federal privacy regulations.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Advanced Foot & Ankle Clinic, it's employees or agents, to release all medical information to:

- All insurance carriers, health-plan administrators, or any other payers, including the Centers for Medicare & Medicaid Services (CMS), their agents or review agencies for processing health care claims.
- The person(s) I designate as my billing address for handling the billing, payment and health care coverage for my account;
- My other health care providers for treatment or payment purposes.

AUTHORIZATION TO ASSIGN BENEFITS & RELEASE INFORMATION

- I authorize my insurance carrier, health-plan administrator or any other payer to pay directly to Advanced Foot & Ankle Clinic any benefits due under the terms of my health care plan(s) for services provided by Advanced Foot & Ankle Clinic. I understand that Advanced Foot & Ankle Clinic reserves the right to refuse or accept assignment of medical benefits. If my health care plan will not allow direct payment to Advanced Foot & Ankle, I agree to immediately forward all health care payments I receive for services provided by Advanced Foot & Ankle. I also authorize Advanced Foot & Ankle Clinic, its employees or agents, to contact my insurance carrier, health plan administrator, or any other payer, their agents or review agencies, to obtain all pertinent financial information concering coverage and payments made under my health care plan(s). I further authorize my insurance carrier, health plan administrator or any other payer, their agents or review agencies, to release such information to Advanced Foot & Ankle Clinic, its employees or agents.
- I authorize Advanced Foot & Ankle Clinic, to examine, perform tests, to administer treatment and to perform such procedures; including minor operative procedures as deemed necessary in the diagnosis and/or treatment of my foot/feet condition(s).
- I recognize my financial obligation of any co-insurance, deductibles, and/or non-covered services that may be required.

"H I P P A" privacy

NOTICE OF PRIVACY PRACTICES AKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality asessments and physician certifications.

I acknowlege that I have had the opportunity to receive the *Notice of Privacy Practices* containing a more complete description of the uses and practices of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time, and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PAYMENT FOR SERVICES

Payment for services is due at the time services are rendered UNLESS payment arrangements have been made in advance. Additionally, co-payments must be made at the time services are rendered.

PAYMENT TYPES ACCEPTED

We accept cash, check, money orders, Visa, MasterCard and Discover. For your convenience we can handle automatic credit card payments, as well.

REFERRALS

If your insurance company requires a referral from your primary care physician in order to be treated by our doctors, please verify that this process has taken place. If a referral is not in place, please ask our receptionist for a form to initiate the process.

INSURANCE INFORMATION

You are responsible for supplying us with the correct insurance information. We will submit appropriate insurance claims to your primary and secondary insurance carriers. However, the patient, or guarantor is responsible for all fees, regardless of insurance coverage and payments.

USUAL AND CUSTOMARY FEES

We are committed to providing the best treatment for our patients, and our charges are within the ranges of what is usual and customary for this area. However, many insurance carriers will have their own interpretation of what this means. Not all services we provide are covered benefits in all insurance contracts.

WORK/AUTO RELATED INJURIES

We are happy to provide treatment for work and automobile related injuries. However, all charges incurred are ultimately the responsibility of the patient. You must supply us with your date of injury, allowed diagnoses, your other insurance provider and your claim number. Payment from the patient is expected, unless we are made aware of the necessary information to submit a claim for services rendered on a timely basis. Insurance companies have strict time filing guidelines.

BILLING STATEMENTS

You will only receive a statement from this office when the owed amount is your responsibility. Please pay your bills promptly. If you feel that your insurance carrier has not paid correctly, please contact them instead of our billing office. We will not be able to provide you with any specific information regarding your particular insurance coverage and policy information.

PAST DUE ACCOUNTS

Accounts that are 90 days past due could be subject to collection action. Our goal is to have balances paid in full by this time period. If you are unable to pay your account balance in full, payment arrangements can be made. If you have any questions about your bill or need clarification of the policies listed above, do not hesitate to contact our billing office.

FINANCIAL POLICIES FOR MEDICARE AND/OR MEDICARE ADVANTAGE PLANS

Participating Physicians

We are "participating physicians", this means that we must accept Medicare's allowed charges for the services rendered, writing off the difference between our usual and customary fee and what Medicare approves. Medicare will send a check directly to our office for 80% of the approved amount. The patient is responsible for the 20% of the approved charge, plus the ANNUAL deductible (if the deductible has not been met.) If you have a secondary/supplemental insurance, please make sure Medicare and our office are aware of the secondary insurance information. We will submit a claim for any remaining balance after Medicare has paid to that secondary insurance. Please remember that, although we will accept assignment for Medicare patients, the beneficiary as required by federal law, is responsible for 20% of the approved amount, unmet deductibles, and non-covered services.

Foot Care Service and Non Covered Services

When you receive routine foot care services and items that are not covered by Medicare, you are responsible to pay for them. Medicare does not pay for all your health care costs and Medicare only pays for covered services. Typically, your Medicare Advantage and Supplemental plans will follow Medicare's rules, so will not pay either.

This advance notice is to help you make an informed choice about whether or not you want to receive foot care services such as routine nail care, corns and callus coverage or custom foot orthotics, knowing that you will probably have to pay for them yourself, as these are typically excluded from paid services with Medicare. **A NARROW EXCEPTION OF COVERAGE FOR** routine foot care: nails, corns and calluses are provided with patients with diabetes (with exception to custom orthotics which are NEVER covered).

Protocol for Resolving Complaints

The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services. Service, equipment, and billing complaints will be communicated to management and upper management. These complaints will be documented in the *Medicare Beneficiaries Complaint Log*, and completed forms will include the patient's name, address, telephone number and health insurance claim number, a summary of the complaint, the date it was received, the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint. All complaints will be handled in a professional manner. All logged complaints will be investigated, acted upon, and responded to in writing or by telephone by a manager within a reasonable amount of time after the receipt of the complaint. If there is no satisfactory resolution of the complaint, Dr. Barry Butler or Dr. Andrew Highum will be notified.

ATTENTION: Please sign and date this page, and return ALL 5 pages

Signature

This is a legal document, please read carefully. By signing you agree that you understand and accept the terms on these five pages of forms.

Page 1	Patient Information	Page 2	Medical History
Page 3	Assign & Release Information/HIPPA	Page 4	Financial Policy
Page 5	Signatures		

- If the patient is 18 years of age or older, the patient must sign and date the form.
- If the patient is 18 years of age or older, and is incapable of signing, a legally authorized substitute may sign and date the form.
  - -Please indicate your legal authority: ☐**Legal Guardian or Conservator** ☐**Healthcare Agent (Healthcare Power of Attorney)**
- If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law.
  - -Please indicate your relationship: ☐**Parent** ☐**Legal Guardian**

Signature (Required)	**Date of Signature** (Required)
Printed Name of Person Signing (if NOT patient)	**Relationship** (if not patient)

For purposes of these forms, Advanced Foot & Ankle Clinic refers to Advanced Foot & Ankle Clinic, LLC

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the *Notice of Privacy Practices Acknowledgement,* but was unable to do so as documented below: