



PLEASE FILL OUT THIS FORM COMPLETELY AND TO THE BEST OF YOUR KNOWLEDGE

PATIENT DEMOGRAPHICS

Patient's Name: _____ Today's Date: _____
 Address: _____
 City, State & Zip Code: _____
 Social Security Number: _____ Home Phone: _____
 Cell Phone: _____ Cell Phone Carrier: _____
 Email Address: _____ Date of Birth: _____
 Race: _____ Ethnicity (Check One): HISPANIC LATINO NOT HISPANIC OR LATINO
 Primary Language: English Spanish German Russian Other: _____
 Pharmacy: _____ Phone #: _____
 Pharmacy Address: _____
 If Referred, Name of the Person/Physician/Advertisement Referring: _____
 Primary Care Physician (PCP): _____ PCP Date of Last Visit: _____
 Diabetic Physician: _____ Date of Last Visit: _____
 Emergency Contact: _____ Phone #: _____ Relationship: _____

PRIMARY INSURANCE INFORMATION

SECONDARY INSURANCE INFORMATION

Name of Insurance: _____ Name of Insurance: _____
 Policy Holder: _____ Policy Holder: _____
 Relationship: _____ Relationship: _____
 Date of Birth: _____ Date of Birth: _____

REASON FOR TODAY'S VISIT

Describe Your Foot/Ankle Problem: _____
 Where Is the Pain/Problem Located: _____
 How Long Has It Been Bothering You: _____ Days _____ Weeks _____ Months _____ Years
 How Severe Is the Pain/Problem: Mild Moderate Severe Are You in Hospice: No Yes
 Is This a Work-Related Injury: No Yes If Yes, When Was the Date of Injury: _____
 List Your Current Height: _____ Weight: _____ Shoe Size: _____ Are You Pregnant: No Yes

MEDICAL HISTORY (CHECK ALL THAT APPLY TO YOU)

<input type="checkbox"/> No Current Problems	<input type="checkbox"/> Anemia/Clotting Disorder	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Gout
<input type="checkbox"/> HIV Infection/AIDS	<input type="checkbox"/> Heart Problems/Attack	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Disease

MEDICAL HISTORY CONTINUED

<input type="checkbox"/> Alzheimer's/Dementia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Parkinsons Disease
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Diabetes	<input type="checkbox"/> History of Drug/Alcohol Abuse	<input type="checkbox"/> Other:

PRIOR SURGERIES/HOSPITALIZATIONS:	<input type="checkbox"/> No Prior Surgeries/Hospitalizations

MEDICATIONS:	<input type="checkbox"/> No Current Medications

ALLERGIES:	<input type="checkbox"/> No Known Drug Allergies

FAMILY HISTORY (CHECK ALL THAT APPLY)

<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Cardiac Arrhythmia	<input type="checkbox"/> Cholesterol Disease
<input type="checkbox"/> Circulation Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> COPD/Emphysema
<input type="checkbox"/> Asthma	<input type="checkbox"/> Ulcer/GERD	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Anemia
<input type="checkbox"/> Hepatitis A / B / C	<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gout	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Depression
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Infections
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Clotting Disorder	<input type="checkbox"/> Other:

SOCIAL HISTORY (FILL OUT COMPLETELY)

Do You Smoke: No Former Smoker (Quit date: _____) Yes Packs Per Day: _____

Do You Drink Alcohol: No Yes How Much Do You Drink: Light Moderate Heavy

Do You Use Recreational Drugs: No Yes If Yes, What Do You Use: _____

Have You Fallen in the Past Year: No Yes How Many Times: _____ Injury: No Yes

Do you want the opportunity to pay your bill through a text message or an email? No Yes

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

I authorize Ohio Foot & Ankle Specialists (OFAS) and its agents to release my health information for the purpose of payment, treatment and healthcare operations to any of the following: Insurance company and its affiliates, any practitioner, support staff or faculty involved in my plan of care or transfer of care. In addition, I understand that the potential uses and disclosures of my health information are detailed in the privacy policy. The HIPAA notice of privacy practices is available in the office. I have read and/or had the opportunity to read my HIPAA rights.

I designate OFAS (and its agents) as my authorized representative and authorize to act on my behalf to request and receive a copy of the summary plan description, to pursue a benefit claim, appeal an adverse benefit determination and/or file a legal action to recover benefits from my employee plan, insurance policy and third-party reimbursement or prepaid health plan. I understand and agree that my authorized representative shall have full authority to act and receive notices on my behalf with respect to an initial determination of a claim for health benefits relating to treatment and healthcare services received by me/ my child at OFAS, any requests for documents relating to the claims and adverse determination of the claims.

ACKNOWLEDGMENT OF RIGHTS:

- I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.
- I understand that uses and disclosures already made based upon my original permission cannot be taken back.
- I understand that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.
- I understand that the treatment by any party may not be conditioned upon my signing of this authorization (unless treatment sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health.

Signature

Date

CONSENTS & UNDERSTANDING

MEDICAL RECORDS CONSENT: I give consent to Ohio Foot and Ankle Specialists to electronically query and retrieve my medical records for treatment purposes from all available sources. This includes, but is not limited to, demographic information as well as other clinical documentation that may be available through other sources.

REQUEST FOR RELEASE OF MEDICAL RECORDS: I hereby request that my medical records be released to Ohio Foot and Ankle Specialists.

AUTHORIZATION FROM PATIENT OR LEGAL REPRESENTATIVE:

CONSENT TO TREAT: The undersigned consents to any initial or follow up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, physical therapy, home instructions, orthotics, other durable medical equipment, photographing and/or videotaping and/or other services rendered to the patient by Ohio Foot and Ankle Specialists and its providers. The undersigned agrees that it is their responsibility to contact and/or schedule with Ohio Foot and Ankle Specialists for any follow up visits, other services, prescriptions, and items orders for the patient. The undersigned understands that Ohio Foot and Ankle Specialists providers exercise their care with responsible skill and diligence, but makes no guarantee as to the results that will be attained.

ASSIGNMENT OF BENEFITS: I hereby irrevocably assign, to transfer and convey to Ohio Foot and Ankle Specialists and any practitioner providing care and treatment to me/my ward/child, any and all benefits and all interests and rights (including causes and action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee benefit plan sponsored by my employer, all policies, benefits, any third party reimbursements or prepaid health care plan or services or products that I receive from Ohio Foot and Ankle Specialists.

MEDICARE ASSIGNMENT: I certify that the information given by me in applying for payment under XVII of the social security act is correct and agree to complete the Medicare screening form annually. I authorize the release of information about me to the social security administration or its intermediaries and any information needed for filing a Medicare claim. I request that payment and authorized benefits be made on my behalf. I assign benefits payable for services to Ohio Foot and Ankle Specialists.

AUTHORIZATION TO RELEASE INFORMATION: I consent and authorize Ohio Foot and Ankle Specialists and its agents to release my health information for the purpose of payment, treatment and healthcare operations to any of the following: Insurance Company and its affiliates, any practitioner, support staff or faculty involved in my plan of care or transfer of care. In addition, I understand that the potential uses and disclosures of my health information are detailed in the privacy notice. The HIPPA notice of Privacy Practices is available in the office and posted in the lobby. I have read/had the opportunity to read my HIPPA rights, which include Ohio Foot and Ankle Specialists fees for records.

DESIGNATION OF AUTHORIZED REPRESENTATIVE: I designate and appoint Ohio Foot and Ankle Specialists (and its agents) as my authorized representative and authorize it to act on my behalf to 1) request and receive a copy of the summary plan description, to 2) Pursue a benefit claim, 3) appeal an adverse benefit determination and/or 4) file a legal action to recover benefits from my employee benefit plan, insurance policy and any third party reimbursement or prepaid health plan. I understand and agree that my authorized representative shall have full authority to act and receive notices on my behalf with respect to an initial determination of a claim for health benefits relating to treatment and healthcare services received by me/my ward/child at Ohio Foot and Ankle Specialists, any requests for documents relating to the claims and adverse determination of the claims.

FINANCIAL AGREEMENT: I hereby promise to pay for all products received or services rendered to me/my child to the extent I am legally responsible for such payment according to the language of the physician's insurance contract. I understand that I am responsible for all health insurance copayments, deductibles, coinsurance's, over the counter, convenience items, non-covered services, and any other amounts that apply at the time of service and at the pre-operative appointment. Regardless of the assignment of benefits, should the insurance misrepresent their coverage or delay payment of a claim greater than 60 days, as the designated responsible party I am responsible for all the monies owed to Ohio Foot and Ankle Specialists. I also understand that the insurance policy is a contract between me and the insurance company, therefore the policy holder should contact the insurance carrier first when there are questions regarding the explanation of benefits. The undersigned

certifies that she has read and understands the foregoing and is either the patient or duly authorized by the patient as the patient's general agent to execute the above and accepts its terms. This document shall remain in force until a written revocation by me is delivered to Ohio Foot and Ankle Specialists.

CREDIT CARD ON FILE: Our policy requires that your credit card be swiped, like any other credit card transaction, and held in an encrypted file with GLOBAL PAYMENTS, a confidential secure third party, where permitted. Your insurance company will process your claims, pay their portion and notify us of the total patient responsibility. The credit card on file is a method of payment for balances and non-covered items after claims are adjusted by the patient's insurance. This policy does not apply to patients enrolled in Medicare, Medicaid, or Medicare or Medicaid HMOs. Your credit card information is kept confidential and electronically secure by Global Payments. Charges to your credit card are made only after the claim has been filed and processed by your insurance and the insurance portions of the claim have been paid, adjusted and posted to your account. Once your insurance company has processed your claims, they will send an Explanation of Benefits (EOB) to both you and our office showing your total patient responsibility. You will receive the EOB before we do, so if you disagree with the patient amount owed, it is your responsibility to contact your insurance carrier immediately. When we receive the EOB, we will enter this information into our system and subtract the payments and adjustments required by the insurance company. The remaining balance will be only what the insurance company has determined you owe on the claim. Once that information is entered into our system, your credit card will be charged up to \$250 (or an agreed upon installment) on the 1st business day of each month until your balance is paid in full. It is your responsibility to ensure that the card you have on file is not expired or cancelled and has an appropriate amount of available credit. Please call our office immediately if you need to update your credit card on file. This authorization is effective until revoked in writing. Full Copay amounts will still be due at the time of your visit.

NOTIFICATION OF OFFICE POLICIES AND PROCEDURES: Reading the following policies and procedures annually will keep you informed about our office.

APPOINTMENTS: To allow for greater access to care, our team of physicians are available by appointment during posted hours.

CHARGES FOR MISSED APPOINTMENTS: Any established patient who fails to show up for their appointment and has not contacted our office with at least 24-hour notice will be considered a no-show and may be charged a \$25.00 missed appointment fee. Surgery/Procedure missed appointments will be charged a \$75.00 fee. Pre-operative or post-operative missed appointments less than 90 days from the surgery will be charged a \$50.00 fee. This is not covered by insurance. Charges will be applied where permitted; no charges will be assessed for Medicare, Medicaid or BWC patients.

EMERGENCY/AFTER HOURS: During a medical emergency, patients should call 911 or proceed to the nearest emergency room. For non-emergency, please call our answering service.

BENEFITS: Ohio Foot and Ankle Specialists will reiterate the benefits disclosed to us by your insurance plan. We will then collect based on the benefit level all applicable copays, deductibles, coinsurances, and balances that apply at the time of service.

PAYMENT: Copays are required at the time of service per insurance contract. If your deductible has not been met, it is required that payment be made towards your deductible amount on services rendered at the time of service.

COMPLETION OF FORMS: We reserve the right to charge a \$20.00 fee where permitted for the completion of forms, including FMLA forms. No fees will be charged where they are not permitted, such as BWC forms.

INSURANCE CLAIMS: Ohio Foot and Ankle Specialists files claims electronically for the patients for primary contracted plan and accepts payments via the patient's assignment.

MULTIPLE POLICIES: When multiple policies exist, it is the policy holder's responsibility to inform us of their primary plan. Delaying filing to the primary plan can result in violating timely filing limits, resulting in denial of service and full patient responsibility.

INSURANCE NETWORKS: Ohio Foot and Ankle Specialists only files claims with carriers with whom we have a contractual relationship.

MEDICAL RECORDS: Fees for medical records may be charged as permitted by the Ohio Department of Health.

NON-COVERED SERVICES: Ohio Foot and Ankle Specialists will not submit claims for non-covered OTC items.

PAST DUE ACCOUNTS: Ohio Foot and Ankle Specialists will send a statement to the mailing address you provide notifying you of any outstanding balances. If you do not respond to the first statement within 30 days of receipt and additional statements are mailed out, a \$5.00 re-billing fee will be added to the third statement. If you are unable to pay your balance in full, you are responsible for contacting our billing department to discuss a possible payment plan. If you then fail to make payments, your account may be referred to a professional collection agency and/or attorney and will be subject up to a \$15.00 or 30% collection fee, whichever is greater.

PRESCRIPTION REQUESTS: Ohio Foot and Ankle Specialists ask that you address your prescription refill request at your appointment. All after-hours phone calls/messages related to prescription requests will NOT be addressed until the following business day. All Ohio Foot and Ankle Specialists physicians prescribe Narcotic Medications only in cases of acute injury and after surgery for a pre-stated period. If you require long term pain control, you will be referred to a Pain Management Specialist.

REFERRALS: Ohio Foot and Ankle Specialists may refer patients to other providers, facilities, and labs. Ohio Foot and Ankle Specialists is not responsible for these entities. The patient should contact these providers, facilities, or labs directly regarding any billing inquiries. The policy holder is also responsible for all insurance prior authorizations, and/or managed care referrals necessary for payment to Ohio Foot and Ankle Specialists.

RETURNED CHECKS: A \$30.00 fee will be assessed on all returned checks. Any non-sufficient fee or closed account will result in future services on a prepay cash or credit basis.

REFUNDS: Ohio Foot and Ankle Specialists issues patients refunds by check within 30 days of a completed investigation of the potential overpayment if other outstanding accounts are resolved.

RETURNS: Only unworn and non-custom items are returnable within 14 days of receipt if no visible signs of wear, tear, or odor. Custom items are specifically tailored to meet individual needs and are not returnable and/or refundable.

CONSENT TO RETRIEVE MEDICATION HISTORY FROM THE PHARMACY: I give consent to Ohio Foot and Ankle Specialists to retrieve and use my medication history from SureScripts.