Eagle-Summit Foot & Ankle, P.C.

Brian T. Maurer, DPM
Andrew S. Bernhard, DPM

PATIENT INFORMATION

First Name: MI: Last Name: Today's Date: / /

Mailing Address: City: State: ZIP: Social Security #:

Primary Phone: Secondary Phone: Other Phone: E-mail Address:

Date of Birth: _____/_____/_____ Age Sex Male / Female Marital Status: ❒Single ❒Married ❒Divorced ❒Widowed

Partner's Name:_____

Ethnicity: ❒ Hispanic or Latino ❒ Not Hispanic or Latino

Language: ❒ English ❒ Spanish ❒ Other: _____

Race: ❒ American Indian or Alaska Native ❒ Asian ❒ Black or African American ❒ White

Employer: Occupation:

Primary Care Physician:

INSURANCE INFORMATION

If the patient is NOT the primary subscriber for the insurance please complete below.
Name: _____
Date of Birth: _____/_____/_____
Relationship to Patient: _____
SS#: _____
Address: _____
_____

Please provide the name of the parent or legal guardian, if it is applicable, or if the patient is under the age of 18 years.

Please provide an emergency name and contact number:

Pharmacy: City:

Is your foot problem the result of an accident? ❒ Yes ❒ No If yes, what was the date of the injury? _____/_____/_____

Where did the injury occur? _____ If this happened at work, has your employer been notified? _____

Is this a Worker's Compensation case? _____ Case #: _____

PRIMARY PHYSICIAN / REFERRAL

Referred By:

❒ Dr._____
❒ Website *(www.esfootankle.com)*
❒ Yellow Pages
❒ Friend/Family Member _____
❒ Newspaper Ad
❒ Insurance Company

Signature: _____

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CURRENT FOOT OR ANKLE PROBLEM

Please explain the reason for this visit: _____

_____

When did your problem begin? _____

What have you done to relieve your foot or ankle problem? _____

GENERAL MEDICAL HISTORY

Height:	Weight:	Shoe Size:

ALLERGIES:

❒ **NO KNOWN DRUG ALLERGIES**

❒ Penicillin ❒ Codeine ❒ Local Anesthetics
❒ Sulfa Drugs ❒ Demerol ❒ General Anesthesia
❒ Eggs ❒ Aspirin ❒ Adhesive Tapes
❒ Latex ❒ Advil/Aleve ❒ Iodine/Shellfish

Other: _____

PREVIOUS SURGERY:

❒ No surgical history

_____

_____

_____

_____

_____

FAMILY HISTORY:

Disease/Disorder	Father	Mother
Cancer		
Cardiovascular Disease		
Diabetes		
Foot Problems		
High Blood Pressure		
Melanoma		
Osteoarthritis		
Rheumatoid Arthritis		
Stroke		

MEDICATIONS/HERBS/VITAMINS/SUPPLEMENTS:

❒ No Medications/Supplements/Vitamins

Medication	Dosage	Frequency

MEDICAL HISTORY: check conditions you have or had

❒ **None** **Are you pregnant? Y / N**

❒ Acid Reflux (GERD)
❒ AIDS/HIV ❒ Dizziness/fainting ❒ Mitral Valve Prolapse
❒ Alzheimer's ❒ Drug/Alcohol depend. ❒ Myocardial Infarction
❒ Anemia ❒ Deep VeinThrombosis ❒ Neuropathy
❒ Angina ❒ Emphysema ❒ Night Cramps
❒ Anxiety ❒ Epilepsy/Seizures ❒ Osteoarthritis
❒ Arrhythmia ❒ GI/Rectal Bleed ❒ Osteoporosis/penia
❒ Asthma ❒ Gout ❒ Peripheral Vascular Dis.
❒ Bleeding Disorder ❒ Hepatitis ❒ Phlebitis
❒ Blood Clots ❒ Hernia ❒ Psychiatric Disorder
❒ Bowel Disorder ❒ Herpes ❒ Rheumatoid Arthritis
❒ Bronchitis ❒ High Cholesterol ❒ Sciatica/Back Problems
❒ Cancer_____ ❒ High Blood Pressure ❒ Stomach Ulcer
❒ Cardiac Arrest ❒ Kidney/Bladder Dis. ❒ Stroke/CVA
❒ Cardiac Disease ❒ Leg Ulceration ❒ Thyroid Disorder
❒ Coronary Artery Disease ❒ Low Blood Pressure ❒ Tuberculosis
❒ Depression ❒ Lymphedema ❒ Varicose Veins
❒ Diabetes ❒ Migraine/Headache ❒ Other: _____

SOCIAL HISTORY:

Alcohol use: ❒ None ❒ Rarely ❒ Daily ❒ Moderate ❒ Quit

Tobacco smoking: ❒ Never ❒ Light ❒ Heavy ❒ Former

Other Drug use: ❒ No ❒ Yes

Printed Name: Signature:

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act), 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 assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy* from time to time and that I may contact this organization at any time at the address above 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 healthcare operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions. Eagle-Summit Foot & Ankle, P.C. will at times need to contact you regarding your medical care, billing or another issue. The ways in which we may contact you include: telephone, e-mail, and mail.

Signature: _____ Date: _____/_____/ _____

Assignment of Benefits
Authorization to Release Information to My Insurance Company
Medication History

I, the undersigned certify that I (or my dependent) have insurance coverage with the above plan(s), and hereby assign all insurance benefits, if any, otherwise payable to me, directly to Eagle-Summit Foot & Ankle, P.C., Dr. Brian Maurer and/or Dr. Andrew Bernhard for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits from my insurance company(ies).
I authorize the use of my signature below to reflect my agreement and authorization for the above for all insurance submissions.

I authorize Eagle-Summit Foot & Ankle, P.C. to obtain my medication history.

Signature: _____ Date: _____/_____/ _____

Medicare Authorization

I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf directly to Eagle-Summit Foot & Ankle, P.C. Dr. Brian Maurer and/or Dr. Andrew Bernhard for services rendered. I hereby authorize the doctor to release to the Centers of Medicare and Medicaid Services (CMS) all information necessary to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Section 9 of the HCFA 1500 claim form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-payment, and charges associated with non-covered services. Co-payments and deductibles are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: _____ Date: _____/_____/____

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Financial Contract

Welcome and thank you for choosing Eagle-Summit Foot & Ankle, P.C. for your foot and ankle care. In our effort to provide personalized patient care in the most effective and efficient manner possible, we ask that you take a few moments to read our Financial Contract. If you have any questions now, or in the future regarding our office policies please do not hesitate to contact us. We will do our best to answer your questions.

Your clear understanding of our Financial Policy is important to our professional relationship. We are a Medicare provider and also a provider for most of the insurance plans in the area. It is **your** responsibility to make sure we are in-network with your insurance plan. If your insurance requires a referral or prior authorization, it is **your** responsibility to make sure that it is in place prior to your appointment. We will be glad to assist you if you needed.

As a courtesy to you, we will bill insurance companies with which we are contracted. If we are not contracted with your insurance company, we will do our best to let you know at the time of your visit. **All co-payments and co-insurance payments are due at the time of your visit. If you have an unmet deductible, we will collect at the time of service 60% of the charges incurred that your insurance will apply towards your deductible.** Complete payment for all over the counter products, non-covered products and services and supplies are due at the time they are sent to the supplier or dispensed, whichever comes first. Any over-payment will be refunded after the final insurance adjudication is received and processed.

If you have a secondary and/or tertiary insurance, we will bill them one time. If your secondary insurance does not pay the balance within 45 days, the balance will be billed to you and due at that time.

A consistent attempt will be made to collect outstanding account balances. Past due accounts, more than 90 days, will be turned over to a collection agency. An additional 38% will be added to the balance to cover collection costs (8% interest and 30% collection fee).

I have read the above policy and understand my financial responsibility to Eagle-Summit Foot & Ankle, P.C for the medical services and products provided. I agree to pay Eagle-Summit Foot & Ankle, P.C, any balance due and/or unpaid by my insurance carriers for myself or the person named below.

Patient's Name: _____

Responsible Party Signature: _____Date: _____