



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: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Partner's Name: _____		
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White		
Employer:				Occupation:		
Primary Care Physician:						
If the patient is a MINOR:		Legal Guardian:		Date of Birth of Legal Guardian: _____ / _____ / _____		

INSURANCE INFORMATION

<p>If the patient is NOT the primary subscriber for the insurance please complete below.</p> <p>Name: _____</p> <p>Date of Birth: _____ / _____ / _____</p> <p>Relationship to Patient: _____</p> <p>SS#: _____</p> <p>Address: _____</p>	<p>Please provide an emergency name and contact number:</p> <p>Preferred Pharmacy: _____ City: _____</p>
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Is your foot problem the result of an accident? Yes No

Where did the injury occur? _____

Is this a Worker's Compensation case? _____

If yes, what was the date of the injury? _____ / _____ / _____

If this happened at work, has your employer been notified? _____

Case #: _____

REFERRAL SOURCE

<p>Referred By:</p> <p><input type="checkbox"/> Dr. _____</p> <p><input type="checkbox"/> Website (www.esfootankle.com)</p> <p><input type="checkbox"/> Yellow Pages</p>	<p><input type="checkbox"/> Friend/Family Member _____</p> <p><input type="checkbox"/> Newspaper Ad</p> <p><input type="checkbox"/> Insurance Company</p>
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Signature: _____



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

- | | | |
|--------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Demerol | <input type="checkbox"/> General Anesthesia |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Adhesive Tapes |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Advil/Aleve | <input type="checkbox"/> 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**
- | | | |
|--|---|---|
| <input type="checkbox"/> Acid Reflux (GERD) | <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Drug/Alcohol depend. | <input type="checkbox"/> Myocardial Infarction |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Night Cramps |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> GI/Rectal Bleed | <input type="checkbox"/> Osteoporosis/penia |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Gout | <input type="checkbox"/> Peripheral Vascular Dis. |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hernia | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Bowel Disorder | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sciatica/Back Problems |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney/Bladder Dis. | <input type="checkbox"/> Stroke/CVA |
| <input type="checkbox"/> Cardiac Arrest | <input type="checkbox"/> Leg Ulceration | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Cardiac Disease | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Migraine/Headache | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes | | |

SOCIAL HISTORY:

- Alcohol use: None Rarely Daily Moderate Quit
- Tobacco smoking: Never Light Heavy Former
- Other Drug use: No Yes

Printed Name: _____

Signature: _____



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. Kaitlyn 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. Kaitlyn 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: ____/____/____



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 insurances 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: _____