Ankle and Foot Associates PC

Patient Information

28 Yarmouth Crossing Drive Yarmouth, ME 04062 Phone: 207-846-0802 Fax: 207-847-4005

Please fill out each in its entirety

PATIENT DEMOGRAPHICS

Name:_____ DOB:____/____/____ SSN: _____-_____-_____

Sex: (Circle) M F Marital Status: Single___ Married___ Divorced___ Widowed___ Other___

Address:_____ City:_____ State:_____ Zip:_____

Primary Phone: (____)_____-_____ Secondary Phone: (____)_____-_____

Email Address:_____

Race: American Indian___ Alaska Native___ Asian___ Black/African American___ Hawaiian/Pacific Islander___ White___
Other___ Prefer not to answer___ Ethnicity: Hispanic/Latino___ Not Hispanic/Latino___ Other___

Primary Language: Arabic___ Somali___ Spanish___ English___ French___ Other___

Designation of certain relatives, close friends, and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payments relating to my healthcare. In that case, the Physician/Practice will only disclose information that is directly relevant to the person's involvement with my healthcare or payments related to my healthcare.

Emergency Contact_____ Relationship_____

Phone: (____)_____-_____ Secondary Phone: (___)_____-_____

Responsible Party Information

Please fill this section out if someone other than the patient is responsible for paying any balance due to AFA PC. This is whom any statements will be mailed to. This section must be filled out if the patient is a minor.

Name:_____ DOB: ____/____/____ SSN: _____-_____-_____
Relationship to Patient:_____ Phone: (___)_____-_____ Billing Address:_____
City:_____ State:_____ Zip:_____

PRIMARY CARE DOCTOR

Name:_____ Date of last visit:_____

Pharmacy:_____ Town:_____

INSURANCE

Primary Insurance:_____

Secondary Insurance:_____

HIPAA ACKNOWLEDGMENT AND DESIGNATION DISCLOSURE FORM AND ATTEST

By subscribing my name below, I acknowledge that I can be provided a Notice of Privacy Practices (NPP)
I do herby attest that this information is true, accurate, and complete to the best of my knowledge. I understand that falsification, omission, or concealment of any material fact may subject me to all fees for service and/or other liability. I also understand that I am to notify Ankle and Foot Associates PC immediately of any changes to the above information and annually upon the office's request.

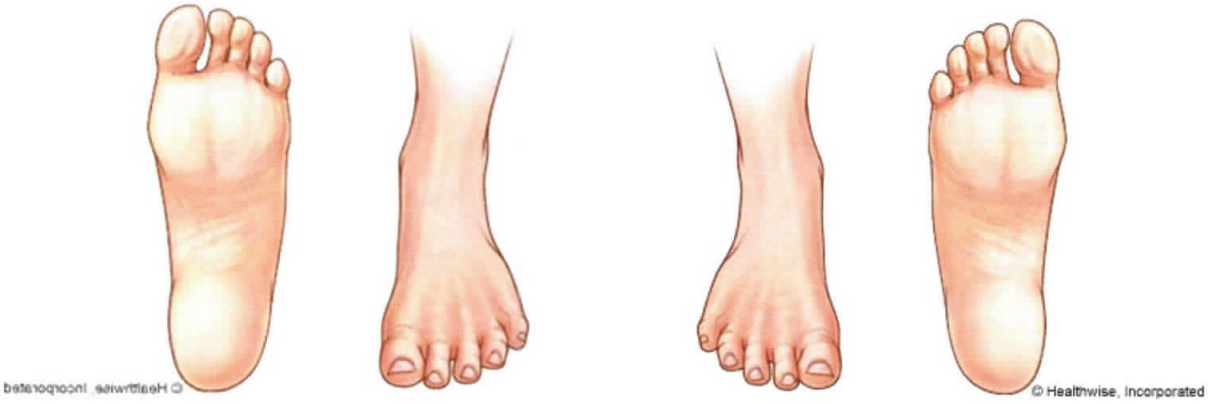
Understanding all of the above, I hereby provide informed consent for treatment to Ankle and Foot Associates PC.

Signature:_____ DATE: _____/_____/_____

Patients Current Chief Complaint

Left Foot

Right Foot



Indicate the location of your problem or pain on the diagram above

Pain Scale: 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Severe Most Severe

What are we seeing you for?

_____

_____

I would describe my pain as: ☐ No Pain ☐ Dull ☐ Sharp ☐ Throb ☐ Burn ☐ Numb ☐ Tingling ☐ Deep ☐ Shooting ☐ Other

Do you remember any trauma or incident which may have caused this? ☐ Yes ☐ No ☐ Unsure

Pain occurs when: ☐ Walking ☐ Standing ☐ Running ☐ Wearing Shoes

FOR STAFF USE ONLY

Shoe Size:

Height:

Weight:

BP:

Pulse:

A1C Level:

Notes:

MEDICAL HISTORY

Allergies: Is there a history of skin reaction, other outward reactions or sickness following an injection or oral/topical administration of the following:

☐ Penicillin ☐ Latex/Adhesive tape ☐ Bacitracin ☐ Tylenol ☐ Codeine ☐ Shrimp, Iodine
☐ Motrin, Aspirin ☐ Morphine ☐ Benadryl ☐ Sulfa Drugs ☐ Neosporin ☐ Betadine
☐ Ibuprofen ☐ Cephalosporin's ☐ Mycins ☐ Anesthetic ☐ Naprosyn ☐ Other:_____

Surgical History: Have you had any of the following procedures:

☐ Achilles Tendon Release ☐ Amputation ☐ Ankle fracture surgery ☐ Arterial bypass ☐ Foot Surgery
☐ Bunionectomy ☐ Spleen ☐ Hammer toe repair ☐ Toenail removal ☐ Knee/Hip
☐ Foot Fracture Surgery ☐ Heart Surgery ☐ Joint Replacement ☐ Cancer ☐ Appendix
☐ Vascular ☐ Gallbladder Surgery Type:_____
☐ Other:_____

Foot/Ankle History: Have you ever been treated for: (select all that apply)

☐ Corns/Calluses ☐ Warts ☐ Athlete's Foot ☐ Fungal Nail ☐ Ingrown Nail
☐ Neuroma ☐ Bunions ☐ Leg/Foot Ulcers ☐ Foot Numbness ☐ Leg/Foot Swelling
☐ Broken Foot/Ankle ☐ Arch Pain ☐ Hammer/Mallet Toe ☐ In-Toeing ☐ High Arch Feet
☐ Knee Pain ☐ Ankle Sprain ☐ Toe Walking ☐ Heel Pain ☐ Leg/Foot Pain
☐ Gait ☐ Childhood Foot Problems

Medical History: Have you ever been treated for: (select all that apply)

☐ Blood Clots ☐ Acid Reflux (GERD) ☐ Anxiety ☐ Diabetes I/ II ☐ Cancer
☐ Callus Formation ☐ Circulation Problems ☐ Fibromyalga ☐ Foot Ulceration ☐ Heart Disease
☐ Liver disease ☐ Hepatitis _____ ☐ Lung Problems ☐ High Blood Pressure ☐ Lupus
☐ Kidney Infection ☐ Congestive Heart Failure ☐ Arthritis ☐ Gout ☐ Osteoporosis
☐ Stroke ☐ MRSA ☐ Cholesterol ☐ Bleeding Disorder ☐ Heart Attack
☐ Pain in Legs/Feet ☐ Neurological Disorder ☐ Stomach Ulcers ☐ RSD/CRPS ☐ Neuropathy
☐ Swelling in Legs/Feet ☐ Chemotherapy ☐ Kidney Stone ☐ Sport Related Injury ☐ Depression
☐ Osteoporosis ☐ Currently Breast Feeding ☐ Osteopenia ☐ Seizure Disorder ☐ Thyroid Disorder
☐ Mitral Valve Prolapse ☐ Other:_____

Current Symptoms: Are you currently experiencing any of the following: (select all that apply)

☐ Weight Change ☐ Sleep disorder ☐ Rash/Hives ☐ Mole Changes ☐ Skin Cancers
☐ Thick Nails ☐ Cataracts ☐ Glaucoma ☐ Glasses/Contacts ☐ Prostate Problems
☐ Hearing Problems ☐ Balance Problems ☐ Ulcer/GERD ☐ Abdominal Pain ☐ Asthma/Emphysema
☐ Heart Burn ☐ Persistent Cough ☐ Cramps in bed ☐ Irregular Beat ☐ Blood Clots
☐ High Blood Pressure ☐ Heart Valve Problem ☐ Vein Problems ☐ Clotting Problems ☐ Bruise Easily
☐ Swollen Glands ☐ Transfusion ☐ Seizures/Strokes ☐ Dizzy Spell ☐ Numbness/Tingling
☐ Bone/Joint Pain ☐ Sprain/Strain ☐ Anxiety ☐ Depression ☐ Bipolar/Obs. Comp

☐ Other:_____

Are you Diabetic? ☐ Yes ☐ No ☐ Type 1 ☐ Type 2

Name of Endocrinologist:_____

Are you currently pregnant? ☐ Yes ☐ No
If yes, are you breast feeding? ☐ Yes ☐ No

Past Medical History: Has one of these family members had any of the following:
Diabetes: ☐ Mother ☐ Father **Cancer**: ☐ Mother ☐ Father **Heart Disease**: ☐ Mother ☐ Father
Stroke: ☐ Mother ☐ Father **High Blood Pressure**: ☐ Mother ☐ Father **Arthritis**: ☐ Mother ☐ Father

Medication List:

_____

_____

Are you slow to heal after cuts? ☐ Yes ☐ No
Any abnormal bruising, bleeding, or scaring? ☐ Yes ☐ No
Are you a current or former smoker? ☐ Never ☐ Current ☐ Former
How long have you smoked: ____Years; ___Months When did you quit: _____
How many packs per day do/did you smoke:_____

Are you a current or former drinker? ☐ Never ☐ Current ☐ Former
How many alcoholic drinks per: ___Day; ___Week; ___Month; ___Year

Illicit/Recreational Drug Use: ☐ Never ☐ Current ☐ Former ☐ Methadone
What drugs have you used: ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Pain Meds ☐ Other
Have you ever taken drugs via syringe or IV (intravenously)? ☐ Yes ☐ No

Prescription Monitoring Program

NOTIFICATION: Ankle and Foot Associates PC participate in a Prescription Monitoring Program (PMP) which is a system in which controlled prescription drug data is collected in a database, centralized by each state, and administered by an authorized state agency to promote the appropriate use of controlled substances for legitimate medical purposes, while deterring the misuse, abuse, and diversion of controlled substances.

Prescription Refill Policy:
1. Only one pharmacy may be used for filling prescriptions. You should notify us if you change pharmacies.
2. Contact your plan regarding your drug coverage
3. Refills are completed via a pharmacy request
4. Because most physicians are only in clinics 3-4 days per week, prescription refills may take 3-5 business days to process.
5. Take your medications or prescriptions as instructed by your provider. Never change the dosage or frequency of your medication without instructions from your physician.
6. Refill requests will not be approved if you "run out early". You are responsible for keeping your prescriptions and medications safely in your care. Lost or stolen medications or prescriptions will not be replaced until your next refill. Exceptions may be made if you have a police report, but only at the discretion of your doctor.
7. You may be required to see your physician for a follow up visit prior to obtaining a medication refill
8. No refills past 12pm Friday to 8am Mondays. Any refill requests ordered on Friday will not be able to pick up, or ePrescribe, until the following Monday or business day providing holidays.
9. **Controlled substances will only be prescribed for post-surgical pain control and in the event of a severe injury (fracture etc.) the decision will be made at the discretion of your physician. After initial prescription an additional request for controlled substances (ie pain medication) will only be provided after thorough assessment by your physician. Requests will not be taken over the phone. If you feel that it is an emergent situation at the time of your request, and your physician is unavailable, you will be instructed to go to your local emergency department for an evaluation.**

By signing this consent form you are agreeing that Ankle and Foot Associates PC can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes. Understanding all of the above, I hereby provide informed consent to Ankle and Foot Associates PC to enroll me in the ePrescribe Program. **The Undersigned certifies that He/She has read, understood, and accepts the terms and has had the opportunity to receive a copy for their records.**

Signature of Patient or Representative:_____ Date:___/___/___

FINANCIAL INFORMATION

Traditional Medicare Insurance:
Our office participates with Medicare. This means we will send your claim to Medicare and we will adhere to Medicare's allowed fee schedule. Medicare sets an allowable fee for each service that they cover. Once you have met your annual deductible, Medicare will pay us 80% of the allowable fee and you will be responsible for the remaining 20%. If you have a secondary insurance this amount will then be sent to them and you will be billed for any remaining balance after their payment.

Medicare has strict guidelines concerning their coverage of routine foot care such as trimming nails, or pairing corns and calluses. The doctor will be able to determine if your routine foot care is or is NOT covered by Medicare. **Should you have a non-covered service such as this performed, you will be asked to pay for that service at the time of visit. We will also ask you to sign Medicare's Advanced Beneficiary Notice (ABN) indicating you were informed that Medicare will <u>not</u> be paying for that particular service.** The ABN will be provided at time of visit.

If you have any other service such as new patient office visit, a visit for a new problem on or around routine nail care or, another non-covered service, Medicare will be billed for the covered service and we will collect the uncovered service fee from you that day as well.

All Other Insurances including Medicare Replacement Plans:
Ankle and Foot Associates PC will submit your claims to all other companies providing:

- At each visit we receive a copy of all current insurance cards.
- Our Patient Information is current and correct.
- Our Financial Policy is signed.

For your convenience, Ankle and Foot Associates PC accepts cash, Visa, MasterCard, Discover, debit cards, and personal checks. Payment is expected at each visit.

You will receive a billing statement for all personal balances due. If we have not received a response from you by phone or received a payment/letter regarding your unpaid balance within 120 days, your account will be sent to our collections department

Total Account Balance (including collections)	Payoff Time	Payment needed to meet guidelines
$0-100	3 Months	$10-34 per month
$101-250	6 Months	$17-42 per month
$251-1,000	12 Months	$21-84 per month
$1,001+	18 Months	$56+ per month

No Insurance:
If you do not have health insurance, charges for the day's medical service are due at time of visit unless other arrangements have been made with the office. In many cases, a cash payment discount may be given to patients without insurance.

There is a $35 fee assessed for returned checks. Ankle and Foot Associates PC understands that unexpected financial problems arise. We encourage you to contact us at (207)761-3889 to help assist in managing your account.

Referrals/Authorizations:

It is the patients responsibility to obtain all referrals if your insurance requires one. We will do all we can in assisting you, but it is ultimately the patients responsibility. If a referral is required and NOT in place PRIOR to your appointment, we may ask to reschedule until the referral is received.

Collections:

Ankle and Foot Associates will attempt to make payment terms that meet your needs. If we don't hear from you by phone, mail, or partial payment within 120 days (three statements sent to you without payment), you may be referred to a collection agency. In the event your account is sent to collections, the patient agrees to be responsible for a 25% collection fee, and all court costs/attorney fees.

- I understand that if a custom DME product is ordered for me, such as orthotics or special shoes, or I receive an air cast, night splint, surgical shoe, ankle brace, or Pure Stride inserts, that they are non-refundable and non-returnable. If my insurance denies them for any reason, I understand it is my responsibility and I will pay for the product(s) I received
- I understand that Ankle and Foot Associates PC's financial policy is in effect the entire time that I am a patient, not just for the date I sign this policy. If Ankle and Foot Associates has any change in policy we will ask that you fill a new form out at that time.
- I authorize Ankle and Foot Associates to release information regarding my medical history and treatments to my insurance company in order for them to be paid. I also authorize payments for services to be paid directly to Ankle and Foot Associates from my insurance company.
- I understand that unpaid balances have to be paid prior to making a follow up appointment. I understand that I will speak with a person of the office staff to initiate a payment plan if my balance is unmanageable.

I acknowledge by signing my name below, as the patient or guardian of the patient, that I have read and understood all of the above financial disclosures and will comply. I have asked questions if necessary, and I have had my questions answered and I understand.

Print:_____

Signature:_____ Date:____/____/____