FOOT & ANKLE SPECIALISTS, PLLC

PATIENT REGISTRATION FORM

Today's Date _____/_____/_____

PATIENT INFORMATION (PLEASE PRINT)

❑ Ms. ❑ Mrs. ❑ Mr. | Patient's Last Name | First | Middle

Date of Birth / / | Age | Sex ❑ M ❑ F | Social Security # - - | Marital Status (Circle One) Single / Mar / Sep / Div / Widow

Street Address | Home Phone No. ( ) -

Apartment # | City | State | ZIP Code

e-mail address: This will be used only if you specifically request (see other side of this form)

Occupation | Employer | Employer Phone No. ( ) -

How did you find us? (Check all that apply) ❑ Dr. | Referral? ❑ No ❑ Yes

❑ Insurance Plan ❑ Hospital or InstaCare ❑ Close to Home/Work ❑ Yellow Pages

❑ Internet ❑ Family ❑ Friend ❑ Other:

INSURANCE INFORMATION (PLEASE GIVE YOUR CARD TO THE RECEPTIONIST)

Is the patient covered by insurance? ❑ Yes ❑ No **Please identify the responsible party in the box below*

Primary Insurance: | Policy Holder's Name:

Policy #: | Group # | Co-Payment $

Patient's Relationship to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other:

Secondary Insurance: | Policy Holder's Name: | Policy # | Group #

* Name of Responsible Party: | Date of Birth / / | Home Phone # ( ) -

Street Address | City | State | Zip Code

IN CASE OF EMERGENCY

Name of Closest Relative or Friend (NOT living at same address) | Relationship to Patient | Home Phone No. ( ) | Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Foot & Ankle Specialists, PLLC and/or my insurance company to release any information required to process my claims. I understand the all information provided will be kept strictly confidential unless otherwise authorized.

X _____

PATIENT, PARENT OR GUARDIAN SIGNATURE DATE

FOOT & ANKLE SPECIALISTS, PLLC

1561 WEST 7000 SOUTH, SUITE 201
WEST JORDAN, UT 84084
PHONE: (801) 569-2696 FAX: (801) 352-0400

NOTICE OF PRIVACY PRACTICES REGARDING PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides detailed information about how we may use and disclose protected health information about you. As a patient, you have the right to a copy of that Notice. You may obtain a copy of the Notice from:

Foot & Ankle Specialists, PLLC
1561 West 7000 South, Suite 201
West Jordan, UT 84084
(801) 569-2696

We reserve the right to change the Notice at any time. If the Notice does change, you may obtain a revised copy at the same location.

I wish to be contacted in the following manner (check all that apply):

- ❑ Home Telephone: ( ) _____ - _____
  - ❑ O.K. to leave message with detailed information
  - ❑ Leave message with call-back number only
- ❑ Work Telephone: ( ) _____ - _____
  - ❑ O.K. to leave message with detailed information
  - ❑ Leave message with call-back number only
- ❑ Written Communication
  - ❑ O.K. to mail to my home address
  - ❑ O.K. to mail to my work address
- ❑ Other:

I will permit the release of information from my medical record, including appointment times and dates to the following persons: _____

_____

I have had an opportunity to read and obtain a copy of the Notice of Privacy Practices. I understand the reasonable steps will be taken to limit the use or disclosure of my health information. I have had an opportunity to ask questions.

Note: Uses and disclosures of protected health information contained in the medical record may be permitted without prior consent in the event of an emergency.

Print Name: _____ Birthdate: _____

Patient Signature: _____ Date Signed: _____

MEDICAL AND HEALTH HISTORY

Patient's Last Name	First	Middle
Primary Care Physician:	Date of Last Exam: / /	
Reason for today's visit:		
Shoe Size:	Height:	Weight: lbs.

HEALTH HISTORY

❑ **I have no past or current health conditions.**

Have you been treated for any of the following conditions, either currently or in the past?

	No	Past	Currently		No	Past	Currently
Diabetes	❑	❑	❑	High Blood Pressure	❑	❑	❑
Thyroid Disease	❑	❑	❑	Heart Attack or Chest Pain	❑	❑	❑
Neuropathy	❑	❑	❑	Heart Murmur	❑	❑	❑
Stroke	❑	❑	❑	Irregular Heart Beat	❑	❑	❑
Cerebral Palsy	❑	❑	❑	Congestive Heart Failure (CHF)	❑	❑	❑
Multiple Sclerosis	❑	❑	❑	Peripheral Vascular Disease	❑	❑	❑
Polio	❑	❑	❑	Blood Clots (DVT)	❑	❑	❑
Seizures	❑	❑	❑	Varicose Veins	❑	❑	❑
Depression	❑	❑	❑	Leg Swelling	❑	❑	❑
Sciatica	❑	❑	❑	Hepatitis	❑	❑	❑
Back Injury or Pain	❑	❑	❑	Jaundice	❑	❑	❑
Osteoarthritis (OA)	❑	❑	❑	Kidney Disease	❑	❑	❑
DJD	❑	❑	❑	Acid Reflux (Heart Burn)	❑	❑	❑
Rheumatoid Arthritis (RA)	❑	❑	❑	Tuberculosis (TB)	❑	❑	❑
Gout	❑	❑	❑	COPD	❑	❑	❑
Skin Wounds or Ulcers	❑	❑	❑	Asthma	❑	❑	❑
Eczema	❑	❑	❑	Shortness of Breath	❑	❑	❑
Psoriasis	❑	❑	❑	Infectious Disease	❑	❑	❑
Cancer	❑	❑	❑	Anemia	❑	❑	❑

Other health conditions not listed above: _____

SURGERIES & HOSPITALIZATIONS

Reason	Year	Hospital

CURRENT MEDICATIONS

Medication Name	Dosage	Frequency

ALLERGIES AND ADVERSE DRUG REACTIONS

Name of Drug	Reaction

FAMILY HEALTH HISTORY

List any medical problems your immediate family members have

HEALTH HABITS (INCLUDES PAST AND CURRENT USE)

Alcohol: ❑ No ❑ Yes	If yes, how many times per week?	How long?
Tobacco: ❑ No ❑ Yes	If yes, how many packs per day?	How long?

Drug use: ❑ Narcotics (prescription pain killers) ❑ Drug rehab ❑ Illegal drugs, which _____

ATTESTATION (PLEASE READ AND SIGN)

The information provided above is correct to the best of my knowledge. I have made no intentional error nor omitted information pertinent to my medical history or current medical status. I understand that omitting information could be dangerous. All information contained in this questionnaire is strictly confidential and will become part of my medical record.

X _____

PATIENT, PARENT OR GUARDIAN SIGNATURE DATE

FOOT & ANKLE SPECIALISTS, PLLC

1561 WEST 7000 SOUTH, SUITE 201
WEST JORDAN, UT 84084
PHONE: (801) 569-2696 FAX: (801) 528-6558

OFFICE FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

1. Health insurance is a contract between YOU and your INSURANCE COMPANY. We DO NOT set the amount of your co-payments, co-insurance, or deductible - your insurance company does that.
2. You are responsible to meet all out-of-pocket expenses as determined by your health insurance (co-payments, deductibles, co-insurance, along with non-covered services and supplies). You are responsible to make any required co-payment at the time of service. Follow-up visits still require a co-payment. There are certain surgical procedures which have a global period during which co-payments are not required. You can ask us if this applies to your care.
3. Payment for services is due at the time medical services are rendered, unless insurance or other arrangements have been made. We accept payment in the form of cash, check, Visa™, MasterCard™, American Express™, and Discover™.
4. We reserve the right to charge a $25 collection fee on any co-payment not made at the time of service.
5. Proof of insurance is required at the time of service. In the event proof of insurance is not provided, we will charge a $100 fee to your account (payable at the time of service) until the insurance claim is adjudicated. This fee will be applied to your account balance.
6. We reserve the right to charge a $35 fee if you no-show an appointment or if you cancel an appointment with less than a 24-hour notice.
7. Health insurance policies vary and specific benefits for each plan are often different. Unfortunately, not all medical services or supplies are covered benefits under every insurance plan. Some insurance companies elect to NOT cover certain services and/or supplies. We cannot guarantee your insurance will pay for services rendered or supplies dispensed through our office. If you have questions about your benefits and coverage, please contact your insurance company directly. Our expertise is *medical care*, not *health insurance*!
8. All charges in our office are your responsibility. Health insurance simply functions as a form of payment. As a courtesy, we will submit insurance claims for you. We will make every effort to first collect from your insurance company, but those balances left unpaid by them are your responsibility.
9. Returned checks are subject to a $35 fee. Outstanding balances older than 30 days are subject to additional collection fees and interest of 1.5% per month. If your account is referred for collections, you agree to pay a collection fee of up to 40% on outstanding balances, attorney fees, court costs, and interest of 1.5% per month.
10. We DO NOT submit anything more than secondary insurance claims. If you have a third insurance, you will need to submit claims yourself.
11. We realize that unfortunate financial problems may affect you and timely payment on your account. We are committed to maintaining a strong relationship with you. If such financial problems do arise, please contact us as soon as possible so we may assist you in managing your account.
12. By signing below, you agree to assign your insurance benefits to Foot and Ankle Specialists, PLLC. You assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under your insurance plan(s) directly to Foot and Ankle Specialists, PLLC and Dr. Trevor R. Williams. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after your insurance has met its obligation.

If you have any questions or concerns about this policy, or if you simply are unsure about your insurance coverage, please don't hesitate to ask us. We're here to help you! I have read the above financial policy and have had an opportunity to ask questions. I understand my financial obligations to Dr. Williams and Foot and Ankle Specialists, PLLC. I agree to abide by this policy regarding my care here.

Signature: _____ Date Signed: _____