CAPITAL FOOT & ANKLE CENTERS

Today's Date:_____ Height_____ Weight_____ Shoe size_____

Allergies (CIRCLE)

None Penicillin Sulfa Drugs Codeine Aspirin Tape Latex Iodine-Shellfish

Other allergies: _____

_____

Medications _____

_____

_____

_____

SOCIAL HISTORY (CIRCLE)

Do you smoke? No Yes _____ pk/day x ____ years. Quit, but I smoked ____ pk/day x ___ years.

Drink Alcohol? No Yes if yes, how often _____

Recreational Drugs? No Yes if yes, how often _____

MEDICAL HISTORY

Diabetes	Yes	No	Asthma	Yes	No	Gout	Yes	No
High Blood Pressure	Yes	No	Kidney Disease	Yes	No	Psoriasis	Yes	No
Heart Disease	Yes	No	Liver Disease	Yes	No	Back Problems	Yes	No
Bleeding Problems	Yes	No	Eye Disease	Yes	No	Stomach Ulcers	Yes	No
Circulation Problems	Yes	No	Urinary Tract Problem	Yes	No	Rheumatoid Arthritis	Yes	No
Lung Disease	Yes	No	Convulsions	Yes	No	Cancer	Yes	No
Stroke	Yes	No	Skin Tumors	Yes	No	Currently Pregnant?	Yes	No

If yes to any of the above, please give details:_____

_____

_____

Previous Surgery & Other Medical Problems:_____

_____

_____

WHERE IS YOUR FOOT/ANKLE PROBLEM?_____

Which Foot? Right - Left - Both Feet

Duration of Problem: _____ day(s) - week(s) - month(s) - year(s)

When does it hurt? (CIRCLE) First Steps in Morning - End of Day - Standing - Walking - Running - At Rest

Other:_____

Any previous treatment? _____

Any previous foot surgery of any kind for this problem or other problems? _____

_____

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PERSONAL INFORMATION

Name: _____
Last First Middle

Address: _____

Zip:_____City:_____State:_____

Phone:_____Work phone:_____

Cell:_____Email:_____

Occupation:_____

Employer_____

Primary Doctor:_____

Doctors Location:_____

Patients Gender: Male or Female
(Circle)

Birth Date:_____/_____/_____

Social Sec #_____

Marital Status: Single – Married - Widow
(Circle)

INSURANCE INFORMATION

Name of Subscriber:_____Subscriber's Birth Date:_____/_____/_____

Insured Address:_____

How Patient is Related to Insured: Self or Spouse or Child or Other:_____

Primary Insurance Co:_____Secondary Insurance Co:_____

ID Number:_____Copay_____

IS THIS INJURY RELATED TO: Auto Accident or Worker's Compensation

IF YES, please list the date of the injury:_____

WHOM MAY WE THANK FOR REFERRING YOU?

Primary Doctor - Yellow Pages - Insurance Book - Internet - Other:_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT

1. I authorize the release of any and all medical infomratin necessary to process this claim.
2. I hereby authorize direct payment of surgical.medical benefits to CAPITAL FOOT & ANKLE CENTERS, PC for services rendered in person or under direct supervision of the physician. I request payment from my insurance company be made directly to CAPITAL FOOT & ANKLE CENTERS, PC.
3. I certify that the information I have reported with regard to my insurance coverage is correct.
4. I understand I AM FINANCIALLY RESPONSIBLE for any balance not covered by my insurance company.
5. I permit a copy of this authorization to be used in place of the original.

_____ _____
Signature (Parent or Guardian of minor) Date

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Capital Foot & Ankle Centers, PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Capital Foot & Ankle Centers, PC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Capital Foot & Ankle Centers, PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Capital Foot & Ankle Centers, PC - Privacy Official at **2270 Jolly Oak Rd, Suite 1 Okemos, MI 48864**.

With this consent, Capital Foot & Ankle Centers, PC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Capital Foot & Ankle Centers, PC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Capital Foot & Ankle Centers, PC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Capital Foot & Ankle Centers, PC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Capital Foot & Ankle Centers, PC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Capital Foot & Ankle Centers, PC may decline to provide treatment to me.

_____
Signature of Patient (Or Parent of minor/ Legal Guardian)

_____ _____
Patient's Name Date

_____
Print Name of Patient (Or Parent of minor/Legal Guardian)

Please Complete Back Of Form

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Medical information about our patients is strictly confidential and will not be released to anyone but the patient. There are times, however, when it may be convenient or necessary to give medical information to persons other than yourself. Please list below any persons and their relationship to you, to whom you would allow us to release medical information.

○ **Please check if you would like no one, but yourself to receive medical information.**

The following persons may receive medical information regarding you as our patient.

Name	Relation
_____	_____
_____	_____
_____	_____

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FINANCIAL POLICY AND OFFICE POLICY

We are pleased that you have chosen us as your podiatric care provider. Our physicians and staff are dedicated to providing our patients with the best possible care and customer service. Please understand that payment of your bill is considered part of your treatment. We must emphasize that as physicians, our relationship is with you, NOT your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility. The following is a statement of our financial and other office policies.

NO SHOW POLICY: Our physicians and staff respect the time that you take to come to your appointment as well as the arrangements that may be necessary in order for you to be here. We do our best to run as close to your scheduled appointment time as possible. Please be sure to arrive at your scheduled appointment time. We have reserved this time especially for you. We understand that unexpected things may come up that could prevent you from keeping your appointment with us. However, every time a patient does not notify us that they will be unable to keep an appointment, it prohibits another patient from being able to see one of our providers. Therefore, we want to let you know what our policy is with regards to patient "no shows". We request that you let us know at least 24 hours prior to your appointment time that you will be unable to keep your scheduled appointment. If you do not, you may be assessed with a "no show" and billed $50 for the missed appointment. This charge is not covered by insurance and will be the responsibility of the patient (or parent/guardian if the patient is a minor). Three "no shows" in 12 months may result in your being discharged from our practice in which case no further appointments will be scheduled for you. Thank you in advance for your consideration and thoughtfulness in this matter. It is very important to us that we are serving all of our patients as effectively and efficiently as possible.

LATE POLICY: If you arrive more than 7 minutes after your scheduled appointment time, your appointment may be rescheduled for another day. New patients should arrive 20 minutes before their scheduled appointment time in order to ensure that all required paperwork is completed. Please understand that the practice of medicine does involve people, so emergencies and unanticipated delays do sometimes occur. So if we are able to accommodate your late arrival without delaying subsequent patients, we will make efforts to do so. We pledge to keep you informed of any delays that may occur on our end.

INSURANCES: We participate in many insurance plans, including Medicare. It is your responsibility to check with your insurance plan to see if a physician participates with your insurance plan. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. If you are not insured by a plan we do business with, payment is expected at each visit. All insurance carriers have a schedule of fees from which they will pay; however, the doctor's fees may be more than what the insurance company will pay. Any balance not covered by your insurance company will become your responsibility.

We accept CASH, CHECK, VISA and MASTERCARD. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If something happens to not be covered by your plan, you are responsible for the payment in full. We will bill your insurance company all remaining charges as a courtesy to you. However, our office is not responsible for following up with your insurance company to ensure that they provide reimbursement. This is your responsibility. We will try our best to assist you with claims billed to your insurance company.

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Private Insurance: If you have private health insurance, we will be happy to file your insurance claim in lieu of full payment at the time of service. You will be asked to pay only the amounts not covered by your insurance (such as copays, deductibles and co-insurance) at the time services are rendered. If, for any reason, your insurance company has not paid the balance within 60 days from the billing date, the balance will automatically be billed to you for full payment. Again, we will assist you in any way we can to get the balance paid.

Managed Care Plan: If you are a member of a Health Maintenance Organization, (HMO) or other managed care plan, in most cases your payment to us is limited to a co-payment. You must have your insurance card and a referral (if your insurance requires one) at the time of your visit. Your coverage may be limited though, and may not include items such as orthotics or other equipments. Should you and the doctor decide to proceed with these services, this will be an out of pocket expense and will be payable at the time of service. If you do not have a referral and you choose to be seen by the doctor, payment in full for services rendered will be required at the time of the visit.

Medicare: We accept Medicare's allowable as full payment. We will file your claim with Medicare. You will be required to make payment at the time of service for your co-insurance amount (20% of allowable) and for any portion of your deductible which has not been met. Please be aware that some and perhaps all of the services (i.e. orthotics, routine foot care) provided may be non-covered services under Medicare program. You will be responsible for payment of non-covered services at the time they are rendered.

LATE PAYMENTS: Any non-covered services or amounts not paid by your insurance company are due within 30 days of the billing date. A late fee of 1.5% will be added to the unpaid balance of your account that is more than 60 days overdue.

COLLECTION ACCOUNTS: Our office will make every effort to communicate with you about your account and will present reasonable options for payment. If you have a balance on your account, we will send you a monthly statement. If your account is over 90 days past due without contacting our billing department to discuss payment options, the account will be turned over to collections. If your account is sent to our collection agency, a collection charge of 30% of the amount due will be added to the balance of your account. If legal action is necessary to collect your obligation to us, you agree to pay all reasonable attorney's fees and costs incurred in collecting your obligation.

DISABILITY INSURANCE FORM COMPLETION AND CHART COPYING: Our office will complete your disability insurance forms. The fee for each form is $40 and must be paid in advance prior to completion of your form. Please allow 10 BUSINESS DAYS for completion of your disability forms. There will be a $25 chart copying fee for any records requested.

CHECKS RETURNED FOR INSUFFICIENT FUNDS: If we receive a returned check for insufficient funds, we will immediately reverse the payment on your account and will also charge a $40.00 fee to your account. Payment must be made via Check or Credit Card.

SELF-PAY POLICY: Payment is expected at the time of service. Prompt pay discounts may be available, please check with practice staff for details.

SURGERY: We may require a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. If so, a cost estimate which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan, will be explained to you.

MINORS: All minors (17 years and younger) must be accompanied by a parent or guardian. The accompanying adult is responsible for payment of the account, according to the policy outlined above.

REFUNDS: If a refund is due to you, we will process/issue the refund on or about the 30th of the following month.

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I agree to pay any cost, collection charges and reasonable attorney's fees if outstanding balances are not paid or arrangements made for payment. I understand all accounts older than 90 days will be forward to a collection agency without further notice.

I acknowledge that I was provided a copy of our Privacy Policy (separate attachment) and have read (or have the opportunity to read if I so chose) and understood this Policy.

I hereby assign all insurance benefits, if any, otherwise payable to me for service rendered directly to Capital Foot & Ankle Centers, PC. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize Dr. Joe Gonzalez, DPM to examine and treat my condition as needed, including minor office procedures, and release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I certify the information given is correct and true to the best of my ability. I permit a photocopy of this agreement to be used in place of the original.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. If you have any questions about financial arrangements, please feel free to discuss them with us. We will make every effort available to assist and answer any question you have concerning your account. We are here to help.

SIGNATURE:_____DATE:_____
(Signature of Patient or Authorized Representative)