FINANCIAL DISTRICT
FOOT & ANKLE CENTER

PATIENT INFORMATION

Name _____ What name would you like us to use? _____
First Middle Last

Gender: Male _____ Female _____ Birth Date _____ / _____ / _____ Age _____
Month Day Year

Home Address _____
Street Number Street Name APT # City Zip Code

Home Phone (_____)_____ - _____ Work Phone (_____)_____ - _____

Cell Phone (_____)_____ - _____ Email _____

Which phone number is the best to call you? Home _____ Work _____ Cell _____

Married _____ Single _____ Domestic Partnered _____ Other _____

Employer _____ Occupation _____

Employer Address _____
Street Number Street Name # City Zip Code

Spouse / DP Name _____ Day Phone (_____)_____ - _____

Emergency Contact _____ Day Phone (_____)_____ - _____

Primary Care Dr. _____
First Last

Physician Address _____
Street Number Street Name Suite # City Zip Code

Physician Phone (_____)_____ - _____

How did you come to choose FDFAC for your Podiatric needs?

Yelp Review _____ CitySearch Review _____ Physician Referral _____ Other Medical Referral _____

Location _____ Insurance Website _____ Friend/Colleague _____ Family Member _____

Is there anyone we can thank for referring you? _____

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FOOT & ANKLE CENTER

INSURANCE INFORMATION

Name _____ Birth Date _____ / _____ / _____
First Middle Last Month Day Year

SS# _____ - _____ - _____ Co-Pay Amount $_____

Insurance Company _____ Phone (_____)_____ - _____

Are you the primary holder on the above insurance policy? Yes _____ No _____

If No, please provide name of the primary policy holder: _____

Primary Birth Date _____ / _____ / _____ Employer of the Primary Insured: _____
Month Day Year

Policy ID# _____ Group # _____

Plan Code # _____ Effective Date _____ / _____ / _____

Do you have additonal Health Insurance? Yes _____ No _____ Secondary Insurer _____

Is your visit related to an accident or injury? Yes _____ No _____

If Yes, Type of Injury Auto _____ Work _____ Other ? _____

Date of Injury _____ / _____ / _____ Place of Injury _____

How were you injured? _____

As a convenience, Financial District Foot & Ankle Center will bill your insurance company for fees and services.

Information received by your insurance company does not pre-authorize payment. In order to receive benefits, the member must be covered at the time of service. The benefits information received by FDFAC is not all-inclusive. It is limited to some coverage highlights. Other terms and limitations may apply even though such provisions are not indicated by your insurance provider. All claims are subject to medical review, (by your insurance provider), according to the information submitted by the provider of the service and are subject to benefit maximums and other terms of the member's contract. Please refer to your applicable benefit agreements to determine the appropriate payment amounts and any limitations or exclusions.

FDFAC contracts with an outside billing company, (Computer Billing Services), to handle all billing and insurance payment questions.

NOTE: Some policies require a referral prior to being seen by a specialist. FDFAC has no way of knowing if this will be required until time of billing. We expect our patients to understand their benefits and to have a written referral faxed to our office prior to your first appointment. If this referral is not provided, you as a patient, may not receive benefits and may be responsible for all charges and fees. All Patients are responsible for providing required referrals that any insurer needs to authorize FDFAC as your health care provider.

FDFAC is not an HMO Contractor, Medicare Provider or Workers Comp/QME clinic. FDFAC will not provide you with any more than a financial statement for our services.

Assignment of Benefits: I hereby assign payment directly to Financial District Foot & Ankle Center, the insurance benefits otherwise payable to me. I understand that I am financially responsible for the charges not covered by this authorization. I also authorize a photocopy of this assignment as if it were an original copy. If it becomes necessary for the account to be referred to an attorney for collection or suit, the undersigned shall pay the reasonable attorney's fee and collection expenses. Further, I understand that coinsurance, unsatisfied deductible amounts, etc. are requested at the time of services unless other financial arrangements are made in advance.

_____ _____

Signature Date

MEDICAL HISTORY

Name _____ Chief Foot Complaint _____
(First Middle Last)

Have you been seen by another practitioner for this condition? Yes No

If yes, who did you see and when?

Name _____ Date_____ Outcome _____

Name _____ Date_____ Outcome _____

Name _____ Date_____ Outcome _____

Please check all applicable medical conditions that apply to you:

_____ Arteriosclerosis
_____ Arthritis
_____ Asthma
_____ Anemia
_____ Bronchitis
_____ Cancer
_____ Chronic Cough
_____ Diabetes
_____ Emphysema
_____ Fainting
_____ Glaucoma
_____ Gout
_____ Heart Disease
_____ Hemophilia
_____ Hepatitis
_____ High Blood Pressure
_____ HIV/AIDS
_____ Joint Pain/Stiffness
_____ Kidney Problems
_____ Liver Disease
_____ Muscle Spasms
_____ Pneumonia
_____ Rheumatic Fever
_____ Sinus Troubles
_____ Stroke/Seizures
_____ Thyroid Problems
_____ Tuberculosis
_____ Ulcers
_____ Other _____

Family History:
_____ Arthritis _____ Diabetes _____ Hypertension

_____ Cancer _____ Heart Disease _____ Vascular Disease

Social History:
Do you smoke? Yes | No If yes, how much per day? _____
Do you drink alcohol? Yes | No If yes, how much per day? _____

Surgical History:
1. _____ Year: _____ 3. _____ Year: _____
2. _____ Year: _____ 4. _____ Year: _____

Current Medications:
1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Known Allergies to Medication:
1. _____ 2. _____

_____ _____
Signature Date

This page serves to inform you of the privacy practices of Financial District Foot & Ankle Center and its representatives. The privacy of your medical information is important to us. We intend to honor your privacy in every way possible.

By signing below you will allow us to disclose your personal health information:

• For treatment of your medical condition.

• For help in attaining the maximum benefits allowed by your insurance company.

• To any 3rd party representatives also working in the treatment of your medical diagnosis.

We respect your rights in maintaining the utmost in privacy in regards to your individual health information. We will not release any of your health information to non-medical entities without your prior written permission.

Financial District Foot & Ankle Center maintains physical and electronic safeguards that restrict unauthorized access to your health information. Such safeguards include secured office facilities, locked file cabinets and controlled computer network systems and password accounts.

We will only disclose your medical information to your health plan or other health care professionals or facilities for purposes of diagnosis or treatment of your medical condition. If you prefer that we do not disclose any or all of your medical condition(s), please inform us so that we may take any necessary precautions.

_____ _____

Signature Date

NO SHOW/RESCHEDULE POLICY

We would like to take this opportunity to welcome you to our practice and thank you for choosing our office to provide you with quality podiatric care. Please carefully read, provide all required information and sign the following below.

As part of our service, we try to contain the ever-rising cost of health care. In an effort to do this, we have implemented this No Show Policy which we ask you to read and sign. You may receive a copy of this policy for your records if you so desire. The original will be maintained in your patient chart. It is your responsibility to know the date and time of your reserved appointment and to be ready for your appointment.

CANCELLATION and NO SHOW CHARGE

Every "no-show" delays the opportunity for evaluation for other individuals. We ask for your help with this. By giving advanced notice of cancellation/reschedule, arrangements can be made for another individual wanting to be evaluated to be seen in our clinic. We need at least 2 full business days, (Monday - Thursday), to notify another individual of a cancellation or reschedule.

I understand that a physician and examination room has been reserved for me and if I do not keep my scheduled appointment or if I do not cancel my scheduled appointment at least two business days in advance, I will be charged a "no-show" fee of two hundred fifty dollars ($250.00). I agree to provide my credit card information as a security measure. I understand that I will only be charged according to this "no-show" policy. I also understand that if this fee is not paid it will be sent through the normal collection process.

Multiple cancelations and non-payment of no show fees will result in you being referred to a different medical practice.

Furthermore, I understand that New Patient Forms pages 1 -5 must be fully completed, signed and returned to Financial District Foot & Ankle Center before an appointment can made.

I, _____ have read this No-Show Policy, understand it, and agree to its terms.
(print name)

☐ MasterCard ☐ Visa

_____
Billing Zip Code

_____ _____ _____
Name as if appears on the card | Expiration Date | Today's Date

_____ _____
Account number | Card Holder's Signature

ORTHOTIC COVERAGE

FINANCIAL INFORMATION
Prescription orthotics are a proven medical treatment for many conditions affecting the foot and leg. Orthotics are a cost effective treatment to correct abnormal forces that cause pain and deformities.

Often, the use of orthotics can eliminate the need for long term drug therapy, physical therapy, or surgical correction. Orthotics are covered by many insurance plans as therapeutic and preventive medical devices.

All payments for orthotics are the sole responsibility of the patient.
Any insurance coverage is a contract between you and your insurance carrier.

It is your responsibility as the patient to confirm whether or not your insurance carrier covers prescription orthotic devices and whether they cover the full amount. If your carrier does cover orthotic devices, we will be glad to assist you in billing your insurance, or with certain carriers, bill them for you.

Patient Name:_____ Diagnostic code:_____ Plantar fasciitis 728.71

The following is what you should ask your insurance company in order to determine whether orthotics are covered under your policy:
Procedure Code: L3000-RT and L3000-LT

Are custom foot orthotics covered with your insurance plan? Yes No

If foot orthotics are covered, are they covered at 100%, 80%, some other percentage, or a specific amount? _____

Is prior authorization required before your insurance will cover the orthotics? Yes No

If yes, what is required for pre-authorization? _____

If a letter is required, where do we fax or mail it: _____

If orthotics are covered, how many pairs per lifetime does it cover?
• 1 pair per calander year (Jan - Dec)
• 1 pair per 12 month period
• Unlimited

Do you have a deductible? Yes No

Has your deductible been met? Yes No
If no, how much is due on deductible? $_____

Do you have a health savings account as part of your insurance plan? Yes No

Name of insurance company contact person: _____ Date Called: ___/___/___

Phone Number: _____ Fax Number: _____

If your insurance carrier requires information on your medical condition to determine whether you are covered for prescription orthotics we will work with you to provide that information.

Please return this form to our office at your next visit. We will keep it in your file in case of any problems with your insurance following through on promised payment.