FOOT & ANKLE SPECIALISTS OF NEVADA

Patient Registration Information

☐ New Patient
☐ Established Patient
☐ Established Patient seen more than **3 years ago**

Patient Information

First Name: _____ **Last Name:**_____ **Middle:** _____

DOB: _____ **Sex:** ☐ Female ☐ Male **Marital Status:** ☐ M ☐ S ☐ D ☐ W

Email: _____

Address: _____

City: _____ **State:** _____ **Zip:**_____

Preferred Phone: ☐ Home ( ) _____ ☐ Cell ( ) _____ ☐ Work ( ) _____

How did you hear about us? ☐ **Referral** ☐ **Social Media** ☐ **Ad** ☐ **Search Engine** ☐ **Other**

Primary Care Physician: _____ **Date Last Seen:**_____

Address:_____ **Office Phone:** _____

Primary Insurance Information

Insurance Carrier: _____ **ID Number:**_____

Subscriber Name: _____ **Subscriber DOB:**_____

Subscriber SSN: _____ **Patient Relationship to Subscriber:** ☐ Self ☐ Spouse ☐ Child

Secondary Insurance Information

Insurance Carrier: _____ **ID Number:**_____

Subscriber Name: _____ **Subscriber DOB:**_____

Subscriber SSN: _____ **Patient Relationship to Subscriber:** ☐ Self ☐ Spouse ☐ Child

Emergency Contact(s)

Name: _____ **Relationship:**_____

☐ Home ( ) _____ ☐ Cell ( ) _____ ☐ Work ( ) _____

Name: _____ **Relationship:**_____

☐ Home ( ) _____ ☐ Cell ( ) _____ ☐ Work ( ) _____

May Discuss Health Information or Treatment/Diagnosis with Emergency Contact? ☐ Yes ☐ No

I have answered these questions as truthfully and acurately as possible. If the patient is a minor, then the legal guardian will sign.

Date:_____ **Signature:**_____

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Patient Health Information

First Name: _____ **Last Name:**_____

Current Illness/Chief Complaint:

_____

Onset Date: _____ **Location:**_____ **Pain Level (1-10):** _____

Allergies: _____ ☐ **No Known Allergies**

Preferred Pharmacy:_____ **Phone:** _____

Medical History (Check All that Apply)

☐ Abnormal Bleeding
☐ Acid Reflux
☐ Anemia
☐ Arthritis
☐ Back Pain
☐ Bladder Infections
☐ Blood Clots
☐ Blood Transfusion
☐ Bronchitis/Emphysema
☐ Cancer
☐ Diabetes
☐ Fibromyalgia
☐ Gout
☐ Heart Attack
☐ Heart Disease/Failure
☐ Hepatitis
☐ HIV/Aids
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Migraine Headaches
☐ Neuropathy
☐ Open Sores
☐ Pneumonia
☐ Polio
☐ Rheumatic Fever
☐ Sickle Cell Disease
☐ Skin Disorder
☐ Sleep Apnea
☐ Stroke
☐ Thyroid Disease
☐ Ulcers

Family Medical History (Check All that Apply)

☐ Asthma
☐ Alcoholism
☐ Arthritis
☐ Back Pain
☐ Blood Disorders
☐ Cancer
☐ Diabetes
☐ Epilepsy
☐ Gout
☐ Heart Disease/Failure
☐ High Blood Pressure
☐ Mental Illness
☐ Stroke
☐ Tuberculosis
☐ Other: _____

Current Medications:

Medication:_____ Strength:_____ Dose: _____ per day

Medication:_____ Strength:_____ Dose: _____ per day

Medication:_____ Strength:_____ Dose: _____ per day

Previous Surgeries:

Type of Surgery:_____ Date:_____

Type of Surgery:_____ Date:_____

Do you use tobacco? ☐ Current Smoker ☐ Non Smoker ☐ Former Smoker Packs per Day: _____

Do you use alcohol? ☐ Daily ☐ Frequently ☐ Occasionally

FOOT & ANKLE SPECIALISTS OF NEVADA

Financial Payment Policy

First Name: _____ **Last Name:** _____

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- Full payment is due at the time of service unless your health insurance carrier has made prior arrangements. For your convenience we accept cash, checks or credit cards (i.e.; VISA, Mastercard, Discover and American Express)
- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.
- If your insurance requires a referral it is **your responsibility** to provide the referral to our office prior to seeing the physician. If unable to provide the referral prior to the visit payment in full will be required at the time of the visit.
- If you have Medicare you are responsible for your Medicare deductible (when applicable) at the time of service.
- If you have a secondary insurance plan, as a courtesy, we will forward any balance due to this carrier. If the secondary carrier does not process/pay the claim within 4 weeks, then the balance will become patient responsibility.
- If you have insurance coverage with a plan for which we **do not** participate, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment **are due at the time of the service**.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- Failure to cancel your appointment within 24 hours of your scheduled appointment time will result in a **$50.00** charge.
- **Coverage Changes** - If your insurance changes, it is your responsibility to present the office with the new insurance information. Failure to do so may result is 100% patient responsibility for the uncovered visit.
- **Copay** - The copay is an amount that your health plan requires to pay at the time of service. The payment is due on the date of service.
- **Annual Deductible -** An annual deductible is an amount that your health plan requires you to pay toward your health care costs each year. If you have not met your deductible at the time of service at our office, you will be responsible for payment on that date of service.
- **Balances -** Any processed claims with unpaid balances will be collected at a subsequent visit.
- **Patients without Insurance -** If you do not have insurance or **cannot present a valid insurance card** at the time of service, payment in full will be required.
- **Returned Checks -** The is a servcice fee of **$25.00** for returned checks

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the financial payment policy of Foot & Ankle Specialists of Nevada and agree to abide by its guidelines.

Signature: _____ Date: _____

FOOT & ANKLE SPECIALISTS OF NEVADA

Authorization & Assignment of Benefits

First Name: _____ **Last Name:** _____

- **Acknowledge of Notice of Privacy Practices (HIPPA):** I acknoowledge and agree that I have received a copy of Foot & Ankle Specialists of Nevada notice of privacy practices, an additional copy is available upon request and on our website.

- **Completeness and Accuracy:** I have answered the questions on the intake form to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor of any changes in my medical status and/or the office staff of any changes in my insurance information.

- **Treatment Authorization:** I give consent to Foot & Ankle Specialists of Nevada to perform office-based medical procedures to treat my condition, symtoms, illness or injuries. I also give the same consent for my minor child or children. I acknowledge that I received no warranties or guarantees with respect to the benefits to be realized or consequences of the aforementioned procedure(s)/treatment(s). I understand that should I leave the facility without written consent of my attending physician; I hereby relieve said physician and the facility of all responsibility of my action.

- **Medication History Authorization:** I give consent to Foot & Ankle Specialists of Nevada to access and download my prescription medication history.

- **Release of Medical Information:** I authorize the release of all information necessary to submit, document and process insurance claims on my behalf.

- **Assignment of Benefits:** I assign to Foot & Ankle Specialists of Nevada the payment of any benefits of any and all health insurance and personal injury policies to which I may be entitled.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the Authorization and Assignment of Benefits policies of Foot & Ankle Specialists of Nevada and agree to abide by its guidelines.

Signature: _____ Date: _____