GREEN FOOT & ANKLE CARE, LLC
PATIENT INFORMATION

Please Use Black or Blue Ink

Patient Legal Name: _____ Nickname: _____
FIRST MIDDLE INITIAL LAST

Home Phone: (_____)_____ Cell Phone: (_____)_____

Address: _____
STREET CITY STATE ZIP

Birth Date: _____/_____/_____ SSN: _____-_____-_____ E-Mail: _____

Sex: Male Female Marital Status: Single Married Widowed Divorced Separated

Race: White Black/African American Other: _____ Ethnicity: Hispanic Not Hispanic Primary Language: _____

Employer: _____ Work Phone: (_____)_____

Address: _____
STREET CITY STATE ZIP

Occupation: _____

Responsible Party: _____ Relationship: _____
Home #: (_____)_____Cell #: (_____)_____Work #: (_____)_____
Address: _____
STREET CITY STATE ZIP

Birth Date: _____/_____/_____ SSN: _____-_____-_____ Employer: _____

Do you have a Medical or Financial Power of Attorney? Yes No (If yes, please see note below)

**** If you have a Medical or Financial Power of Attorney, all paperwork must be presented to the office at the time of the appointment. Failure to provide legal documentation may result in the cancellation of the appointment.**

Closest Relative not living with you: _____ Relationship: _____
Home #: (_____)_____Cell #: (_____)_____ Work #: (_____)_____

INSURANCE INFORMATION

PLEASE PRESENT YOUR INSURANCE CARD(S) & DRIVER'S LICENSE TO THE RECEPTIONIST TO COPY

Policy Holder: ☐ Self ☐ Responsible Party (as above)
☐ Other: Complete the following

Primary Insurance: _____
ID #: _____
Group #: _____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber SSN: _____
Subscriber Employer: _____
Subscriber Address: _____
Relationship to Patient: _____

Policy Holder: ☐ Self ☐ Responsible Party (as above)
☐ Other: Complete the following

Secondary Insurance: _____
ID #: _____
Group #: _____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber SSN: _____
Subscriber Employer: _____
Subscriber Address: _____
Relationship to Patient: _____

CONSENT FOR TREATMENT

Must be signed by all patients or guardians prior to being seen by physician

I certify that the information is true and correct to the best of my knowledge. I give my permission to the doctor to examine, photograph, x-ray, administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problems.

_____ _____ _____
Signature of Patient, Parent, Guardian, or Personal Representative | Relationship | Date

MEDICAL HISTORY

Please fill out all blanks, use N/A if question does not apply

Patient Legal Name: _____ **Birth Date**: _____/_____/_____

Are you pregnant? _____ Shoe Size: _____ Weight: _____ Height: _____

Past Medical History – Please circle those that apply

AIDS/HIV	Cancer	Gout	Phlebitis
Anemia	Chemical Dependency	Heartburn/Reflux	Psychiatric Care
Arthritis	Circulatory Problems	Hemophilia	Respiratory Disease
Artificial Implants	Diabetes	Hepatitis	Stroke
Back Problems	Epilepsy/Seizures	High Blood Pressure	Swelling in Ankle/Foot
Bleeding Disorder	Fainting	Kidney Problems	Thyroid Disease
Blood Clots/DVT	Foot Ulcers	Liver Disease	Varicose Veins

Any other medical conditions _____

Surgical History, please list all surgeries _____

_____

Family History, do you have a family history of the following? Please circle the condition(s) and whether that family member is living or deceased. (Immediate family only). If none, please circle N/A.

Mother:	Diabetes	Heart Disease	Hypertension	Living	Deceased	N/A
Father:	Diabetes	Heart Disease	Hypertension	Living	Deceased	N/A
Brother:	Diabetes	Heart Disease	Hypertension	Living	Deceased	N/A
Sister:	Diabetes	Heart Disease	Hypertension	Living	Deceased	N/A

Social History

Do you use tobacco? Yes No If yes, how often? _____

Do you drink alcohol? Yes No If yes, how often? _____

Allergies - Include allergies to medications, food, etc.

_____

Current Medications - Include both prescription and over the counter medications (Attach list if needed)

_____

_____

Chief Complaint(s) _____ **Duration of Symptoms** _____

Have you had previous treatment for this condition? Yes _____ No _____

Is the visit due to an accident? Yes ____ No ____ Have you ever seen a Podiatrist before? Yes ____ No ____

Athletic activities in which you participate (please list and indicate frequency) _____

_____

Family Doctor: _____

Phone: _____ Date Last Seen: _____

Endocrinologist: _____

Phone: _____ Date Last Seen: _____

Other Doctor: _____ Specialty: _____

Phone: _____ Date Last Seen: _____

Pharmacy: Local: _____ Address: _____ Phone: _____

Mail Order: _____ Address: _____ Phone: _____

Referred By: ☐ Family Doctor ☐ Family Member: _____ ☐ Friend: _____

☐ Internet ☐ Phonebook ☐ Sign/In Area ☐ Other: _____

FINANCIAL POLICY

Our goal is to maximize the quality of your care and minimize misunderstandings regarding fees and payment. **To ensure quality communication, it is the patient's (and/or guardian's) responsibility to inquire about Podiatry coverage/limitations prior to any service being performed**. We accept many different insurance plans; however, all plans are not the same and do not cover the same services.

Please note: It is the patient's (and/or guardian's) responsibility to provide correct insurance information. If the current insurance card is not provided, payment in full at the time of the visit is required until we can verify coverage. In addition, it is the patient's (and/or guardian's) responsibility to recognize if a referral is required by their primary care physician. If a referral is required, it must be sent to Green Foot & Ankle Care, LLC prior to the appointment. If there is no referral in place by the time of the appointment, we are either required to reschedule the appointment, or the patient will be responsible to pay for the services provided.

Managed Care Patients/Private Insurance

If you are in a managed care plan (HMO, PPO, IPA) with whom we participate, we abide by our contract with them. We will bill your insurance company; however, you are responsible for paying any Co-pays, Co-insurance and Deductibles required by your plan at the time of treatment.

Medicare Patients

We accept assignment for Medicare but that does not mean that all services are covered. Patients are responsible for paying their annual deductible. You are also responsible for any co-insurance, which is usually 20% of the allowed amount for an item or service.

Uninsured Patients

We follow a set fee schedule for all services. A minimum of $150.00 in the form of cash, check or credit card is due at the time of service. A payment plan may be set up for the remaining balance if charges are above the $150.00 minimum.

All Patients

For your convenience, we accept CareCredit, Visa, MasterCard, Discover, American Express, Debit, Cash or Check. There is a $35.00 service fee for all returned checks. A payment plan may be set up for any balances if needed.

Any appointment cancelled without 24 hours' notice will be charged $35.00.
If you arrive 15 minutes or later to your appointment, the appointment will be rescheduled.

Separate Billing Notice

Please understand you will receive a statement for services from Green Foot & Ankle Care, LLC. If a procedure is performed, you may also receive a separate statement from the lab for pathology testing. You also understand if any services are performed at an outside facility, you may incur expenses with them.

Durable Medical Equipment Policy

It is the policy of this office to help obtain insurance benefits regarding a patient's individual coverage of these items. This is a courtesy, which we are happy to provide; however, Green Foot & Ankle Care, LLC is not responsible for the accuracy of the information received. Information received by phone is not a guarantee of payment and if any doubt exists as to eligibility, it is highly recommended that you check your plan booklet for a detailed outline of your benefits or make a personal phone call to your insurance company. Please note, if these items are denied by insurance due to coverage limitations, the patient hereby accepts responsibility for the cost.

Patient or Authorized Representative's signature represents that you read, understand, and accept these policies.

Signature of Patient, Parent, Guardian, or Personal Representative	Relationship	Date

DISCLOSURE AUTHORIZATION

Patient Legal Name: _____ **Birth Date**: _____/_____/_____

May we leave a message at your home or with other residents? Yes No

May we leave a message on your answering machine/voicemail? Yes No

May we send you an e-mail? Yes No

Which phone would you prefer the reminder call go to? Home Cell

May we send you a text message? Yes No

We now offer a way to access your personal health information through a patient web portal. With this web portal, you can view all your appointments, your medical history and you can send a secure e-mail if needed. If you would like to sign up, please provide your e-mail address below and your login information will be sent to you.

☐ Yes, I am interested, my e-mail address is: _____

☐ No, I do not wish to participate at this time.

Whom may we discuss your medical/financial information with?

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

PRIVACY DISCLOSURE AGREEMENT

Green Foot & Ankle Care, LLC will use and disclose your health information for the following purposes: to treat you, to assist other health care providers in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operation activities, such as quality assessment, licensing, accreditation, and training of students. Except, as stated in more detail, in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you have any questions, concerns, or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices available to you.

Green Foot & Ankle Care, LLC is compliant with HIPAA policies and a copy is available upon request at time of appointment. Please indicate the appropriate box and sign and date below:

Would like a copy _____ **Decline a copy** _____

_____	_____	_____
Signature of Patient, Parent, Guardian, or Personal Representative	Relationship	Date