FASCO

FOOT AND ANKLE SPECIALISTS
OF CENTRAL OHIO

Welcome to our office! We are very pleased to have you with us.
Please fill in all the appropriate blanks below. This information is important for your health and our records.
It also helps in expediting your insurance payment. If you need help please do not hesitate to ask.

PLEASE HAVE YOUR INSURANCE CARD AND PHOTO ID AVAILABLE FOR THE RECEPTIONIST TO COPY.

(PLEASE PRINT)

PATIENT NAME LAST	FIRST	MI	SEX	BIRTH DATE	AGE
HOME ADDRESS STREET	APT. #	CITY		STATE	ZIP CODE
HOME TELEPHONE #	CELL PHONE #	MARITAL STATUS	SOCIAL SECURITY NUMBER		
NAME OF SPOUSE/PARENT OR GUARDIAN		SPOUSE'S/GUARDIAN'S SOCIAL SECURITY NUMBER	SPOUSE'S/GUARDIAN'S BIRTH DATE	SPOUSE'S/GUARDIAN'S CELL PHONE #	
EMERGENCY CONTACT PERSON AND TELEPHONE #			PATIENT'S EMAIL ADDRESS		

PATIENT'S EMPLOYER (OR FATHER'S)		
BUSINESS ADDRESS		
CITY	ZIP	BUS. PHONE #
OCCUPATION		

PATIENT'S EMPLOYER (OR MOTHER'S)		
BUSINESS ADDRESS		
CITY	ZIP	BUS. PHONE #
OCCUPATION		

PRIMARY INSURANCE COMPANY		
ADDRESS		
SUBSCRIBER'S NAME (IF NOT THE PATIENT)		RELATIONSHIP TO PATIENT
ID NUMBER	GROUP NUMBER	DATE OF BIRTH

SECONDARY INSURANCE COMPANY		
ADDRESS		
SUBSCRIBER'S NAME (IF NOT THE PATIENT)		RELATIONSHIP TO PATIENT
ID NUMBER	GROUP NUMBER	DATE OF BIRTH

FAMILY PHYSICIAN	DATE OF LAST VISIT	ENDOCRINOLOGIST	DATE OF LAST VISIT
FORMER PODIATRIST	DATE OF LAST VISIT	WHAT DID HE/SHE TREAT YOU FOR?	

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? (PLEASE LIST THEIR NAME)

PHYSICIAN REFFERAL ______________ WEB-SITE ______________ INSURANCE ______________ SIGN ______________ MEDIA ______________

STAFF MEMBER ______________ PATIENT/FRIEND ______________ MEDICAL RESIDENT ______________

I HEREBY GIVE MY PERMISSION TO THE DOCTORS OF FOOT AND ANKLE SEPCIALISTS OF CENTRAL OHIO TO EXAMINE, PHOTOGRAPH, ADMINISTER TREATMENT AND PERFORM SUCH MINOR OPERATIVE PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FOOT PROBLEM.

SIGNATURE ______________ DATE ______________

PARENT'S SIGNATURE ______________ DATE ______________

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIM. I AUTHORIZE PAYMENT OF MEDICAL/SURGICAL BENEFITS DIRECTLY TO FOOT AND ANKLE SPECIALISTS OF CENTRAL OHIO.

SIGNATURE ______________ DATE ______________

IS THE REASON FOR YOUR VISIT TODAY RELATED TO A WORK INJURY / WORKERS COMPENSATION CLAIM ☐ YES ☐ NO CLAIM #______________

DO YOU HAVE A FIRST REPORT OF INJURY ☐ YES ☐ NO

NAME OF PHYSICAN OF RECORD______________ DATE OF INJURY______________

Financial Policy for Foot and Ankle Specialist of Central Ohio

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high-quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans; however, we encourage you to check with your insurance carrier to confirm our participation. We require that you bring your insurance card with you to each visit so that we may confirm your eligibility. You are responsible for keeping the office informed as to any changes in your insurance contract or carrier information. Please be aware that your insurance policy is a contract between you and your insurance carrier. We are pleased to provide the service of submitting claims for our patients however, we remind you that you are ultimately responsible for payment of any services provided to you.

If you are seeking non-covered service, do not have insurance or if you are a participant in any insurance for which we are not a provider, please be prepared to pay fees at the time services are rendered.

COPAYMENTS AND DEDUCTIBLES: Foot and Ankle Specialist of Central Ohio is **required** by the plans we contract with to collect your co-pay and any unmet deductible at the time of your service. Any questions you might have regarding co-payments and deductibles should be directed to your insurance company or your employer's human resources department. **Knowing your insurance benefits is your responsibility**.

MEDICARE: We are a participating Medicare provider. Medicare, as well as any secondary insurance, will be billed for you. Patients are responsible for paying their annual deductible if not previously met as well as any co-payments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to any secondary insurance after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

NON-COVERED SERVICES: Please be aware that some of the services you receive **may not be covered** or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payments of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow all guidelines of a managed care plan that may require when you visit a specialist, you must have a referral from your primary care physician **prior to seeking specialty care**. If your plan requires a referral, and if you do not have a referral from your primary care physician at the time of the visit, you will be financially responsible for all services due in full upon completion of the visit. You may also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request in a timely manner. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements may be made on a case-by-case basis. We accept the following payment methods: Cash, Check, VISA/MasterCard/Discover, and HSA/HRA. An additional $35.00 will be added to your statement if your check is returned for insufficient funds. In the event your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance. If you do not you will be billed for the outstanding balance.

CHARGES YOU MAY INCUR: If we are asked to complete additional forms or reports for you, there will be additional charges. Form and report completion fees are collected when the request is made. These fees will **NOT** be billed to your insurance company. Additional charges will be assessed for the following but not limited to: Disability Forms, FMLA forms, Copies of Medical Records, Returned Checks, Attending Physician Statement, Over-the-counter medical supplies, x-rays, and Shoe Restocking.

DURABLE MEDICAL EQUIPMENT/CUSTOM ORTHOTICS: Durable Medical Equipment (DME) and custom orthotics may **NOT** be returned.

I have read and agree to abide by the above financial policy and have been given an opportunity to ask questions on any points that I did not understand. I agree to pay Foot and Ankle Specialist of Central Ohio any balance unpaid by my insurance carrier for myself or the below named person.

TREATMENT OF MINORS: A parent/legal guardian must accompany a patient under the age of 18 years old.

ASSIGNMENT OF BENEFITS: I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Foot and Ankle Specialist of Central Ohio, all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the release of my medical information to my insurance carrier or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

Patient's name (Printed): ______________________ Patient's signature: ______________________ Date: __________

FINANCIALLY RESPONSIBLE PARTY:

Print Name: ______________________ Signature: ______________________ Relationship to Patient: __________

Foot and Ankle Specialists of Central Ohio
MEDICAL HISTORY

PATIENT NAME:		**PATIENT DATE OF BIRTH:**	
Height:	Weight:	Shoe size:	Shoe width:
Pharmacy Name:	Phone Number:	Address:	
Chief Complaint:			
When did the problem begin?		Was this the result of an injury? ☐ YES ☐ NO	
Have you seen another Doctor for this condition:	☐ YES ☐ NO		

MEDICAL HISTORY

Do you have Diabetes:	**☐ YES**	**☐ NO**	**If yes, how long:**
How do you control your Diabetes:	☐ DIET	☐ INSULIN	☐ OTHER MEDICATION
What was your last Blood Sugar Level / A1C?			
Do you have an Endocrinologist:	**☐ YES**	**☐ NO**	

Please check (X) if you have ever had any of the following:

☐ **ARTHRITIS**	☐ **DEPRESSION**
☐ Osteoarthritis (degenerative)	☐ **ELEVATED CHOLESTEROL**
☐ Fibromyalgis ☐ Lupus	☐ **HERNIATED DISC**
☐ Rheumatoid ☐ Gout	☐ **HIGH BLOOD PRESSURE**
☐ Other:	☐ **HIV / AIDS**
☐ **BLOOD DISORDER**	☐ **PERIPHERAL NEUROPATHY**
☐ Anemia ☐ Clotting disorder	☐ **RHEUMATIC FEVER**
☐ Leukemia ☐ Proloned bleeding	☐ **SEIZURE DISORDER**
☐ **CIRCULATION PROBLEMS**	☐ **SLEEP APNEA (C-PAP) SETTING:**
☐ Phlebitis ☐ Varicose veins	☐ **THYROID DISORDER**
☐ Peripheral vascular disease ☐ Stroke	☐ **TUBERCULOSIS**
☐ **EAR / EYE TROUBLE**	
☐ Blurred vision ☐ Cataracts	**SURGERIES**
☐ Glaucoma ☐ Ear trouble	☐ HEART ANGIOPLASTY
☐ **CANCER**	☐ HEART BYPASS
Type:	☐ CORONARY ARTERY STENT
☐ **INTESTINAL PROBLEMS**	☐ APPENDECTOMY
☐ Acid reflux ☐ Crohn's disease	☐ PACEMAKER
☐ Irritable bowel ☐ Stomach ulcers	☐ LEG - ANGIOPLASTY / BYPASS
☐ **LIVER DISEASE**	☐ ORGAN TRANSPLANT
☐ Hepatitis ☐ Transplant	☐ BARIATRIC
☐ Fatty liver	☐ GALL BLADDER
☐ **HEART TROUBLE**	☐ HERNIA
☐ Artrial fibrillation ☐ Coronary artery dis.	☐ TONSYLECTOMY
☐ Irregular Heartbeat ☐ Mitral valve prolapse	☐ BONE & JOINT SURGERIES
☐ Tachycardia	☐ Neck ☐ Hip / replacement
☐ **KIDNEY DISEASE**	☐ Back ☐ Knee / replacement
☐ Dialysis ☐ Transplant	☐ Shoulder ☐ Ankle
☐ **ANXIETY**	☐ Elbow ☐ Foot
☐ **ASTHMA**	☐ Hand ☐ Amputation

Continued on other side ....

Foot and Ankle Specialists of Central Ohio
MEDICAL HISTORY

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

☐ **CONSTITUTION**	☐ **GASTROINTESTINAL**
☐ Fever/Chills	☐ Heartburn
☐ Recent illness	☐ Bloody stool
☐ Weight loss (unexplained)	☐ **GENITOURINARY**
☐ **CARDIOVASCULAR**	☐ Painful urination
☐ Chest pain	☐ Blood in the urine
☐ Shortness of breath	☐ **LYMPAHATIC / HEMATOLOGIC**
☐ Cold feet	☐ Swelling lower extremities
☐ Leg Cramps	☐ Easy bruising
☐ **DERMATOLOGICAL**	☐ Poor wound healing
☐ Rash ☐ Athlete's Foot	☐ **MUSCULOSKELETAL**
☐ Redness ☐ Fungal Nails	☐ Low back pain
☐ Itching ☐ Ingrown	☐ Hip pain
☐ Warts	☐ Knee pain
☐ **ENDOCRINE**	☐ Foot / ankle pain
☐ Frequent urination	☐ **NERVOUS SYSTEM**
☐ Excessive thirst	☐ Exremity weakness
☐ **FEMALE REPRODUCTIVE**	☐ Extremity burning
☐ Currently pregnant	☐ Extremity numbness
☐ Breast feeding	☐ Extremity tingling

FAMILY HISTORY - Blood Relatives - Applies to parents

Condition	MOTHER			FATHER		
Cancer	☐	☐ ALIVE	☐ DECEASED	☐	☐ ALIVE	☐ DECEASED
Diabetes	☐	☐ ALIVE	☐ DECEASED	☐	☐ ALIVE	☐ DECEASED
Heart Disease	☐	☐ ALIVE	☐ DECEASED	☐	☐ ALIVE	☐ DECEASED

ALLERGIES - Please circle all that apply

No Known Allergies		Aspirin	Codeine	Cortisone	Iodine	Latex
Nsaids	Sulfa	Penicillin	Tape/Adhesives		Local Anesthetics	
Other:						

CURRENT MEDICATION LIST - If you have a med list, please give to the front desk to copy

NAME OF MEDICATION - CONDITION USED FOR	NAME OF MEDICATION - CONDITION USED FOR
1.	5.
2.	6.
3.	7.
4.	8.

SOCIAL HISTORY

ALCOHOL
☐ Never Drink Alcohol ☐ Occassional/Social Use ☐ Current Everyday Use ☐ Previous Use
TOBACCO ☐ Current Everyday User ☐ Occassional Use ☐ Previous Use ☐ Never Used
☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chewing Tobacco ☐ Dippling Tobacco
ILLEGAL OR STREET DRUGS ☐ Never Used ☐ Current User ☐ Previous User
☐ Current Treatment Program ☐ Past Treatment Program ☐ Maintaining Sobriety
CANNABIS ☐ Never Used ☐ Current Medicinal Use ☐ Recreational Use ☐ Previous Use

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

____________________ ____________ ____________________________ ______

Name of Patient **Date of Birth** **Signature of Patient/Parent/Guardian** **Date**

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Print Name:______________________ **Relationship:**__________ **Phone:** ______________

Print Name:______________________ **Relationship:**__________ **Phone:** ______________

Print Name:______________________ **Relationship:**__________ **Phone:** ______________

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home/ Cell Phone Number on File:

___ OK to leave message with detailed information

___ Leave message with call back numbers only

Work Telephone Number:

____

___ OK to leave message with detailed information

___ Leave message with call back numbers only

Email Communication to Email Address on File:

___ OK to email with detailed information

___ E-mail me at:______________________

Fax Communication:

____

___ OK to Fax at the number listed above

IV. The HIPAA Privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary health care activities related to providing patient treatment, obtaining payment for its services or its internal operations. Also, the Practice does not have to account for disclosures for which I have executed an Authorization permitting disclosures of my PHI.

Date of disclosure request	Disclosed to whom: address/fax	Description of disclosure	Purpose of disclosure	Dates of Service of disclosure	Person completing request	Date completed

1. The above authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive healthcare at the Practice.
2. These Authorizations may be revoked at any time by notifying the Practice in writing at the Practices mailing address marked to the attention of "HIPAA Compliance Officer."
3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
4. I may see and copy the information described in this form, if I ask for it, and I will get a copy of this form after I sign it.
5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.
6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

______________________ ______________________ __________

Name of Patient (Printed) Signature of Patient Date