Active Ankle&Foot CARE SPECIALIST AND SPA

PATIENT INFORMATION
PLEASE PRINT CLEARLY & PROVIDE PHOTO ID

Patient Name_____ **Sex** M ☐ F ☐
Last First Middle Initial
Birthdate ___/___/___ **Age** _____ **Social Security No.** _____

Marital Status Single☐ **Married**☐ **Divorced**☐ **Widowed**☐ **Spouse Name or Responsible Party**_____

Address_____ **City**_____ **State**_____ **Zip Code**_____

Home Phone_____ **Cell Phone**_____ **Business Phone**_____

Email Address _____

Employer Name_____ **Occupation**_____

Business Address _____ **City**_____ **State**_____ **Zip Code**__

Emergency Contact _____ **Phone** _____

Are you currently under a physician's care? No Yes If yes, please explain _____

Your Physician /Dr: _____ **M.D. PHONE #** _____

Pharmacy name/phone # _____

Referred by: ☐ Dr. _____ ☐Friend_____ ☐ Other _____

INSURANCE INFORMATION: ***Please note: if you do not provide the correct insurance information at the time of your visit, we will be unable to bill your insurance company. You will then be responsible for payment in full at the time of the visit. Please provide a copy of your insurance card (s).***

Policy Name_____ **Policy Holder´s Name**_____

Insured´s Date of Birth ___/___/___ **Sex M** ☐ **F** ☐ **Relationship: Spouse** ☐ **Parent** ☐ **Other**_____

Secondary Policy_____ **Policy Holder´s Name**_____

Insured´s Date of Birth___/___/___ **Sex M** ☐ **F** ☐ **Relationship: Spouse** ☐ **Parent** ☐**Other**_____

AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

I the undersigned hereby authorize Active Ankle and Foot Care Specialist, Dr. Sneha Suthar, to render treatment and/or therapy to myself that she deems medically necessary in order to treat the condition and/or conditions I have requested from herself and her staff.

Signature of Patient/Guardian: **Date**

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MEDICAL INFORMATION

THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH

Reason for your visit today? _____

How long has it been bothering you? Days ☐ Weeks ☐ Months ☐ Years ☐

Any past problems with your feet and/or ankles? No ☐ Yes☐ Is the condition a result of an injury? No ☐ Yes ☐

Was this injury sustained at the workplace? No ☐ Yes ☐ Any previous treatments? No ☐ Yes ☐

If yes, please explain_____

Shoe Size_____ Current Weight_____ Height_____

GENERAL HEALTH INFORMATION

Are you allergic to any medications? NO ☐ YES ☐ Please list:_____

Other allergies (i.e., Tape, Adhesive, Iodine, Lates, etc.…_____

Please list all medications **INCLUDING** vitamins, herbal, and over the counter medications you are taking:

_____

_____

Past surgeries (provide dates)?_____

_____

CHECK ALL THAT YOU HAVE OR HAVE HAD A PROBLEM WITH:

☐High Blood Pressure	☐High Cholesterol	☐Respiratory Problems	☐ Back Problems
☐Liver Problems	☐ Stroke Date: _____	☐ Skin Disorder	☐ Hepatitis C Positive
☐Diabetes	☐Rheumatoid Arthritis	☐Anxiety/ Depression	☐ Blood Clots or DVT's
☐Heart Attack	☐Anemia	☐Asthma	☐Mitral Valve Prolapse
☐Gout	☐Bleeding Disorder	☐Poor Circulation	☐ Cancer Type _____
☐Thyroid Disease	☐Seizure Disorder	☐HIV/AIDS	
☐Kidney Problems	☐Neurological Problems	☐Stomach Ulcers	☐Other _____

IS THERE A FAMILY HISTORY (BLOOD RELATIVE) OF THE FOLLOWING?

☐Heart Disease	☐Diabetes	☐Cancer
☐Neurological Disorders	☐Bleeding Disorders	☐Rheumatoid Arthritis

Do you smoke? ☐NO ☐ YES If yes, # packs per day_____

Previously Smoked? ☐NO ☐ YES If yes, for how long?_____

Do you drink Alcohol? ☐NO ☐ YES If yes, how much? ☐ 1-2 drinks per week ☐2 drinks per day ☐More than 2 daily

Forms of Exercise and Frequency:_____

Patient/ Guardian Signature: _____ Date _____

AUTHORIZATION TO UTILIZE UNENCRYPTED EMAIL/TEXT MESSAGING TO COMMUNICATE PROTECTED HEALTH INFORMATION

PATIENT AGREEMENT FOR COMMUNICATIONS

I_____, understand that as part of my health care Active Ankle & Foot Care Specialist will need to contact me from time to time for the purposes of reminding me of an appointment, relaying the results of a test, advising me of special precautions and measure that I need to follow prior to a procedure, to follow up after a procedure, etc. I hereby authorize Active Ankle & Foot Care Specialist to contact me in the following ways:

(Please indicate below)

____ Home Phone (Voice mail) Number:_____

____ Office Phone (Voice mail) Number:_____

____ Cell Phone (Voice mail/ Text) Number:_____

_____ Email Address: _____

I authorize Active Ankle & Foot Care Specialist to speak with the following person/s and release information on my behalf: _____

I understand that Active Ankle & Foot Care Specialist will use the minimum necessary information needed when they communicate with me indirectly. I understand that I can revoke or amend this agreement at any time. Any revocation or change will not apply to communications already complete.

Patient Name: _____ Date of Birth: _____

Date: _____

Print Name: _____

Signature of Patient or Authorized Party: _____

Relation to patient: _____

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AUTHORIZATION TO UTILIZE UNENCRYPTED MAIL/TEXT MESSAGING TO COMMUNICATE PROTECTED HEALTH INFORMATION
EMAIL COMMUNICATION SHOULD NEVER BE USED IN THE CASE OF AN EMERGENCY OF FOR URGENT REQUESTS FOR INFORMATION

Electronic mail (email) and text messages are forms of communication that may be utilized between you and the providers. We want to make sure you know that unencrypted mail and text communication are not secure communications.

Active Ankle & Foot Care Specialist is not able to encrypt text messages. We do have the ability to encrypt email communication of protected health information. Encryption is the process of making information unreadable unless you have the password or key to decrypt the information. We will encrypt email communications unless you advise that you prefer us to use unencrypted email. If it is your preference that we do not encrypt our email communications with you, please initial here: _____

NOTE: If you elect to communicate from your workplace computer, you should be aware that your employer and its agents may have access to email communication between us.

Incoming email communications will be reviewed and answered as soon as possible. If you have not heard from your provider's office with a response and are concerned that your message was not received, please call the office during regular business hours. Emails and text communications may become a part of your patient medical record and be accessible to our clinical support staff as needed for our operations.

Active Ankle & Foot Care Specialist may use text messaging to remind you of upcoming appointments and/or care coordination activities if you have elected to receive reminders in this manner. We will limit information sent via text message to the minimum necessary. Active Ankle & Foot Care Specialist does not encourage text messaging for other purposes.

This authorization may be revoked at any time and must be done in writing. It is understood that the revocation will not apply to information that has already been released based on this authorization.

If you agree to the foregoing terms, please indicate your acceptance by your signature that you accept the terms and conditions outlined herein.

ACCEPTED: Signature of Patient: _____ Date: _____

Printed Patient Name: _____ DOB: _____

Authorized E-mail of Patient: _____

Active Ankle & Foot Care Specialist (herein after collectively referred to as "AAFCS")

Authorization from Patient or Legal Representative

1. **Consent to Treat:** The undersigned consents to any initial or follow-up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, physical therapy, home instructions, orthotics, other durable 1nedical equipment, photographing and/or other services rendered to the patient by AAFCS and its providers. The undersign agrees that it is their responsibility to contact and/or schedule with AAFCS for any follow up visits, other services, prescriptions and items ordered for the patient. The undersigned also understands that AAFCS providers exercise their care with reasonable skill and diligence but make no guarantee as to the results or cure that will be attained.

2. **Assignment of Benefits:** I hereby irrevocably assign, transfer and convey to AAFCS and any practitioner providing care and treatment to me/my child, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I received from AAFCS.

3. **Medicare Assignment:** I certify that the information given by me in applying for payment under XVIII of the Social Security Act is correct and agree to complete the Medicare screening form annually. I authorize the release of information concerning me to the Social Security Administration or its intermediaries as well as any information needed for filing a Medicare claim; I request that payment and authorized benefits be made on my behalf. I assign benefits payable for services to AAFCS.

4. **Authorization to Release Information:** I consent and authorize AAFCS and its agents to release my health information for the purpose of payment, treatment, and healthcare operations to any of the following: insurance company and its affiliates, any practitioner, support staff or facility involved in my plan of care or transfer of care. In addition, I understand that the potential uses, and disclosures of my Health Information are detailed in the Privacy notice. The HIPAA Notice of Privacy Practices are available online at www.ActiveAFC.com Individual copies are also available in the office. I have read/had the opportunity to read my HIPAA rights, which include AAFCS fees for records.

5. **Designation of Authorized Representative:** I designate and appoint AAFCS (and its agents) as my authorized representative and authorize it to act on my behalf to 1) request and receive a copy of the summary plan description, 2) pursue a benefit claim, 3) appeal and adverse benefit determination, and/or any third-party reimbursement or prepaid health care plan. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by me/my child at AAFCS, any request for documents relating to this claim and appeal of any adverse determination of the claim.

The undersigned certifies that he/she has read and understands the foregoing statements 1-5, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accepts it terms. This document shall remain in force until a written revocation by me is delivered to AAFCS.

_____

Printed Name of Patient or Legal Authorized Representative

_____ _____

Signature/ Relationship to Patient **Date**

Active Ankle & Foot Care Specialist

Active Ankle & Foot Care Specialist (herein after collectively referred to as "AAFCS")

Notifications of Office Policies and Procedures

1. Appointments: To allow for greater access of care, our team of physicians is available by appointment during posted hours.

2.Emergency/after hours: During a medical emergency, patients should call 911 or proceed to nearest emergency room. On-call physicians should be paged for post-operative complications and other urgent situations.

3.Refills and Medication: Refill requests are completed within 24 hours of receipt or the next business day. Contact your plan regarding your drug coverage.

4.Messages: Phone messages received before 3 PM are usually returned daily.

5.Benefits: AAFCS will reiterate the benefits that were disclosed to us by your insurance plan. We will then collect based on the benefit level all applicable copays, deductibles, coinsurances and balances that apply at the time of service or at the pre-operative appointment. You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied. To improve accuracy, we update patient records annually.

6.Payment: AAFCS accepts Visa, MasterCard, Discover, Cash or Checks. All checks are immediately scanned for processing. Our office does not accept temporary checks and we will contact the bank directly to verify checks over $300. WE DO NOT ACCEPT PAYMENT PLANS.

7. Insurance Claims: AAFCS files claims electronically for the patient's primary contracted plan and accepts payment via the patient's assignment. In the event the patient does not supply the appropriate information and/or does not reply to requests from their insurance the balance will be billed to the patient.

8.Multiple Policies: When multiple policies exist, it is the policy holder's responsibility to inform AAFC of their primary plan. Delayed filing to the primary plan can result in violating timely filing limits, resulting in a denial of service and full patient financial responsibility.

9.Insurance Networks: AAFCS only files claim to carriers whom we have a contractual relationship.

10.Liability Claims: AAFCS does not accept workers compensation, personal injury protection, and letters of protection or other liability claims. These types of claims are to be paid in full by the patient.

11.Non-Covered Services: All health plans are not the same and do not cover the same services. Io the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered. AAFCS will not submit claims for non-covered items including, but not limited to cosmetic services and over the counter convenience items (OTC e.g., Foot Cream, Coban, Mycomist, etc. ...)

12.Referrals: The policy bolder is also responsible for all insurance authorizations or managed care referrals necessary for payment to AAFCS. AAFCS may refer patients to other providers, facilities, and labs. AAFCS is not responsible for these entities. The patient should contact these non-AAFCS providers, facilities or labs directly regarding any billing questions. Co1npliance with providers, facilities and other treatments impact patient outcomes.

13.Missed Appointments: A $50 charge will apply for appointments broken or canceled without 24 hours advanced notice.

14.Appointment Hold: Repetitive broken appointments, non-compliance, hostile behavior, and/or financially deficient accounts will result in appointment hold and/or the termination of the Active Ankle and Foot Care Specialist Doctor-Patient relationship. 30 days advance notice will be given should the situation result in a transfer of the patient's care.

15.Patient Balance Statements: AAFCS will send a remainder or balance statement to the patient when the benefits have been misrepresented by the carrier. Each additional statement will be assessed a $10 rebilling fee for each month that it is reissued.

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16.Delinquent Accounts: Past due accounts are subject to collection proceedings and are reported. All collection fees, attorney fees and court fees shall become the guarantor's responsibility in addition to the balance due the office.

17. Returned Checks and Declined auto payments: A $30.00 fee will be assessed on all return checks and declined credit card (auto payments only). Any NSF or Closed Account will result in future services on a pre-pay cash or credit basis.

18.Refunds: AAFCS issues patient refunds by check within 30 days of a completed investigation of the potential overpayment, if other outstanding accounts have been resolved. We must receive a written request for a refund of any overpayment.

19.Medical Records: The cost for copied medical records and/ or x-rays will be charged to the patient and collected prior to replicating.

20.Documents: The completion of disability forms and the customized letters will be charged to the patient and collected prior to replicating.

21. **Surgery Deposits**: $150.00 nonrefundable deposits are required for all surgeries. Surgery patients that cancel or reschedule their surgery will lose their full deposit.

22. **Financial Agreement:** I hereby promise that premiums for my insurance are kept current. Furthermore, I agree to pay for all products received or services rendered to me/my child to the extent I am legally responsible for such payment. According to the language of the physician's insurance contract.

I understand that I am responsible for all health insurance copayments, deductibles, coinsurances, OTC (over the counter items) and NCS (non-covered services) and any other amounts that apply at the time of service or at the pre-operative appointment.

Should the insurance misrepresent their coverage or delay payment of a claim greater than 45 days, as the designated responsible party, I am responsible for all monies owed to AAFCS. I also understand that the insurance policy is a contract between me and the insurance company; therefore, the policy holder should contact the insurance carrier first when there are questions regarding explanation of benefits.

The undersigned certifies that he/she has read and understands the foregoing 1-22 statements, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.

_____
Print Name of Patient or Legal Authorized Representative

_____
Signature

_____
Relationship to Patient

_____
Date

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APPOINTMENT CANCELLATION POLICY

Your appointment time is especially reserved for your care. We ask that you give us 24 hours notice to cancel or reschedule an existing appointment. Failure to do so will result in a $50.00 no show fee.

Patient Signature: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

☐ **Yes, I would like a copy of the Notice of Privacy Practices.**

☐ **No, I would not like a copy of the Notice of Privacy Practices.**

_____ _____

Patient Signature Date