

Welcome To
Advanced Foot and Ankle Clinics
 903 SE 22nd ST Suite 1, Bentonville 479-271-5353
 I49 Exit 85 West turning Right on J Street, Left on 22nd

Today's Date: ___/___/___

Patient Information

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone #: (____) _____ - _____
 Cell#: (____) _____ - _____
 Email: _____
 Date of Birth: ___/___/___ Age: _____
 Social Security #: _____ - _____ - _____
 Sex: Male ___ Female ___
 Marital Status: S ___ M ___ W ___ D ___
 Language Spoken: _____
 Ethnicity: _____

Your Occupation: _____
 Employer: _____
 Work #: (____) _____ - _____

Emergency Contact
 Name: _____
 Phone #: (____) _____ - _____
 Relationship: _____

How Did You Hear About Us?

Social History

Alcohol Usage: Yes ___ No ___
 How much: _____ How often: _____
 Tobacco Use: Yes ___ No ___
 How much: _____ How often: _____
 No. of years of tobacco use: _____

Do you use any recreational drugs?
 Yes: ___ No: ___
 If so, what? _____
 How often? _____

Family Physician: _____

Last seen: _____

Are you now, or have you been, under any other doctor's care for any reason the past 2 years?

Yes ___ No ___ If yes, please explain:

Podiatric History

Have you seen a Podiatrist before? Yes ___ No ___

If yes, Dr.'s name: _____

Last Visit: _____

Please indicate which foot/ankle problems you now have or have had in the past.

- | | | |
|---------------------------------|---------|--------|
| Ankle Pain..... | Yes ___ | No ___ |
| Ankle Sprains..... | Yes ___ | No ___ |
| Athlete's Foot..... | Yes ___ | No ___ |
| Bunions..... | Yes ___ | No ___ |
| Corns..... | Yes ___ | No ___ |
| Calluses..... | Yes ___ | No ___ |
| Flat Feet..... | Yes ___ | No ___ |
| Foot Cramps..... | Yes ___ | No ___ |
| Leg Cramps..... | Yes ___ | No ___ |
| Hammertoes..... | Yes ___ | No ___ |
| Heel Pain..... | Yes ___ | No ___ |
| Ingrown Toenail(s)..... | Yes ___ | No ___ |
| Numbness in feet or legs..... | Yes ___ | No ___ |
| Tingling in feet or legs..... | Yes ___ | No ___ |
| Plantar Wart(s)..... | Yes ___ | No ___ |
| Surgery on foot or ankle..... | Yes ___ | No ___ |
| Swelling in feet or ankles..... | Yes ___ | No ___ |
| Ulcers on foot or ankle..... | Yes ___ | No ___ |
| Toenail Removal..... | Yes ___ | No ___ |

What is your chief complaint today?

Shoe Size: _____ Height: _____ Weight: _____

If Over 18, is your Flu Vaccine current? Yes ___ No ___

If Over 65, is your Pnuemonia Vaccine current? Yes ___ No ___

Medical History

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes ___ No ___	Heart Disease	Yes ___ No ___
Alzheimers	Yes ___ No ___	Hepatitis	Yes ___ No ___
Anemia	Yes ___ No ___	High Blood Pressure	Yes ___ No ___
Arthritis	Yes ___ No ___	Hormone Replacement	Yes ___ No ___
Artificial Heart Valves	Yes ___ No ___	Jaundice	Yes ___ No ___
Artificial Joints	Yes ___ No ___	Kidney Problems	Yes ___ No ___
Asthma	Yes ___ No ___	Liver Disease	Yes ___ No ___
Back Problems	Yes ___ No ___	Lung Disease	Yes ___ No ___
Bleeding Disorders	Yes ___ No ___	Neurological Disorder	Yes ___ No ___
Cancer	Yes ___ No ___	Neuropathy	Yes ___ No ___
Chemical Dependency	Yes ___ No ___	Obesity	Yes ___ No ___
Chemotherapy	Yes ___ No ___	Psychiatric Care	Yes ___ No ___
Circulatory Problems	Yes ___ No ___	Respiratory Disease	Yes ___ No ___
COPD	Yes ___ No ___	Rheumatic Fever	Yes ___ No ___
Depression	Yes ___ No ___	Rheumatoid Arthritis	Yes ___ No ___
Diabetes		Skin Disease	Yes ___ No ___
*Insulin Dependent	Yes ___ No ___	Stomach Ulcers	Yes ___ No ___
*Non-Insulin Dependent	Yes ___ No ___	Stroke	Yes ___ No ___
Epilepsy	Yes ___ No ___	Tuberculosis	Yes ___ No ___
Fibromyalgia	Yes ___ No ___	Thyroid Problems	Yes ___ No ___
GI Disease	Yes ___ No ___	Varicose Veins	Yes ___ No ___
Gout	Yes ___ No ___	Pacemaker or Implanted Defibrillator	Yes ___ No ___

Prior surgeries you have had:

Family History

Mother Living: _____ Deceased: _____	Cause of death: _____
Father Living: _____ Deceased: _____	Cause of death: _____
Brother Living: _____ Deceased: _____	Cause of death: _____
Sister Living: _____ Deceased: _____	Cause of death: _____

Medications

Include prescriptions, over-the-counter medications & vitamins

Allergies

Please list all allergies

What pharmacy do you use? _____

Consent

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and/or ankles.

Patient/Guardian Signature: _____

Date: ____ / ____ / ____

General Information:

- * Payment is due in full at the time of service
 - * If you have insurance, your co-pay or co-insurance will be due at the time of service
 - * Insurance benefits and eligibility will be verified prior to services being rendered
 - * We accept cash, checks, debit, credit cards and Care Credit
- (Having insurance is not a guarantee of payment. If your insurance gives our staff incorrect benefits and eligibility for a service, it is still the responsibility of the patient to pay for any and all services/treatment that were performed on your behalf)*

Proof of Insurance:

- * All patients must complete our patient information form before being seen by the doctor. We must obtain a copy of your driver's license/ID and insurance card. If you fail to provide us with the correct insurance information, you may be responsible for the balance of the claim. If required, obtaining the proper referral from your primary care physician is your responsibility.

Patients with Insurance:

- * As a courtesy, we will submit a claim for your visit to your insurance company
- * If the insurance company deems there is a problem with the claim, we will work with their representative to try and fix the problem and resubmit the claim.
- * If your insurance denies a service you are responsible for the amount due for that claim
- * Any and all denials by your insurance will become patient responsibility to pay

Co-payments, Deductibles and Co-Insurance:

- * The co-pay or co-insurance amount is due at time of service
- * If you have not yet met your yearly deductible, the full fee(s) for services rendered will be due at the time of service
- * Even with insurance, some services may be deemed "non covered" and you will be responsible for those fees

Medicare Insurance:

- * After your yearly deductible is met, we will accept assignment of benefits as set forth in Medicare part B plans
- * As set forth in your Medicare handbook, the co-insurance amount is 20% of Medicare's "allowable" will be collected at the time of service if you do not have a supplemental insurance or if the supplemental insurance does not cover the service(s) rendered
- * Medicare does not cover all services. Any non-covered service/treatment must be paid in full at the time of service. Our staff strives very hard to keep patients informed of any non-covered services and will alert you prior to the service if possible.

Non-Covered Services:

- * You are responsible for any non-covered services you choose to receive. Please be aware that some and perhaps all of the services you receive may not be covered by your insurance. Any non-covered service will not be billed to your insurance. Payment will be due at time of service in full.

Patient/Guardian Signature: _____
Relationship to patient: _____

Date: ____/____/____

Office Visits:

- * New patients need to arrive 30 minutes prior to the scheduled appointment time. If you cannot arrive early, your appointment with the doctor may be delayed.
- * Late arrivals of 10 minutes or more may be asked to reschedule
- * All appointment cancellations need to be made 24 hours prior to the scheduled appointment
- * If you miss/no show for your appointment 2 times or more you may not be able to get another appointment.

Prescription Refills:

- * It may take up to 24 hours for a prescription refill request
- * If you call on a Friday for a prescription refill request please note that it will be handled the next business day which would be Monday
- * We will perform a urine test and/or a mouth swab for patients requesting pain prescription refills
- * We will not replace lost or stolen prescriptions

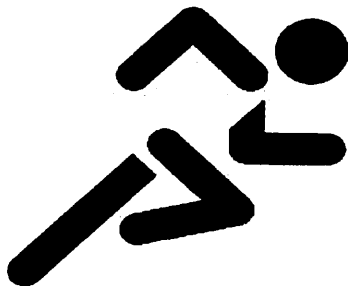
Medical Record Requests:

- * All requests for medical records require a "Medical Record Release" form to be filled out and signed by the patient or guardian requesting the information.
- * It may take up to 72 hours from the time we receive the medical release form in order to get the records ready for you to pick up.
- * It will take 5 business days to complete any paperwork requests from places of employment, disability paperwork, attorney, etc. There is a \$15 fee for all paperwork that needs to be filled out.

Patient/Guardian Signature: _____

Date: ____/____/____

Relationship to Patient: _____



Advanced Foot and Ankle Clinics

903 S.E. 22nd Street, Suite 1
Bentonville, AR 72712
(479)271-5353

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- 1) Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in my treatment directly or indirectly
- 2) Obtain payment from third party payers
- 3) Conduct normal healthcare operations such as quality assessments and physician certifications

I have been given the right to review the Notice of Privacy Practices, found in the waiting room, prior to signing this acknowledgement.

I understand that I may ask for a copy of these Privacy Practices.

I understand that Advanced Foot and Ankle Clinics reserves the right to change these policies at any time and I may contact the office for an updated copy of it at any time.

I understand that I may request, in writing, that Advanced Foot and Ankle Clinics restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare options.

I also understand that if I request my information be withheld from an insurance company, and this withholding affects payment from that company, I will be responsible for payment in full to Advanced Foot and Ankle Clinics.

Patient/Guardian Signature: _____

Printed Name of Signature: _____

Date: ___/___/___

To maintain my privacy practice, I authorize Advanced Foot and Ankle Clinics to release my personal history information in the following manner:

___ A detailed message may be left on my personal number. MY #: _____

___ A message with a call back number only

___ A detailed message may be left at my work. WORK #: _____

___ A message with a call back number only to my work.

Written Communication:

___ It is okay to mail to my home address

___ It is okay to mail to my work

___ It is okay to fax information to me at the following fax #: _____

Other than myself, I only allow _____ (specific person) to receive the following information:

___ Appointment information

___ Billing information

___ Prescription or medication information

Patient/Guardian Name: _____

Date: ___/___/___