



Welcome To
Advanced Foot and Ankle Clinics
903 SE 22nd ST Suite 1, Bentonville 479-271-5353
149 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:

Table with 4 columns: Condition, Yes, No, Condition, Yes, No. Rows include AIDS/HIV, Heart Disease, Hepatitis, High Blood Pressure, Hormone Replacement, Jaundice, Kidney Problems, Liver Disease, Lung Disease, Neurological Disorder, Neuropathy, Obesity, Psychiatric Care, Respiratory Disease, Rheumatic Fever, Rheumatoid Arthritis, Skin Disease, Stomach Ulcers, Stroke, Tuberculosis, Thyroid Problems, Varicose Veins, Pacemaker or Implanted Defibrillator.

Prior surgeries you have had:

Family History

Form for Family History with fields for Mother, Father, Brother, and Sister, including Living/Deceased status and Cause of death.

Medications

Allergies

Include prescriptions, over-the-counter medications & vitamins

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 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: _____**Date:** ____/____/____**Relationship to patient:** _____

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 fee for all paperwork that needs to be filled out and will range between \$15 and \$50 based on the requirements of that paperwork

Patient/Guardian Signature: _____ **Date:** ___/___/___
Relationship to Patient: _____



Advanced Foot and Ankle Clinics

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 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 certification

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

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

___ Appointment information

___ Billing information

___ Prescription or medication information

** You will receive texts about appointments, billing issues, or alerts only. Never marketing.*

Patient/Guardian Name: _____ **Date:** ___/___/___